MDR Tracking Number: M5-03-2207-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5/5/03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The therapeutic procedure, therapeutic activities and electrical stimulation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for therapeutic procedure, therapeutic activities and electrical stimulation.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 12/6/02 through 1/30/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 22nd day of August 2003.

Carol Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

August 15, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE: MDR Tracking #: M5-03-2207-01
IRO Certificate #: 4326

The ___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a ___ physician reviewer who is board certified in family practice which is the same specialty as the treating physician. The ___ physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This patient sustained injuries to his neck and back when he fell ten feet off a ladder on ___. He began a course of physical therapy and chiropractic management. A lumbar MRI dated 09/24/02 revealed disc herniation at L4-5 and L5-S1. Electromyography and nerve conduction velocity study results were consistent with cubital tunnel syndrome bilaterally and compression of the motor roots of the ulnar nerve in the upper extremities and bilateral tarsal tunnel and L4-5 radiculopathy on the right in the lower extremities. He underwent one lumbar epidural steroid injection with no significant relief.

Requested Service(s)

Therapeutic procedure, therapeutic activities, and electrical stimulation from 12/06/02 through 01/30/03

Decision

It is determined that the therapeutic procedure, therapeutic activities, and electrical stimulation from 12/06/02 through 01/30/03 were medically necessary to treat this patient's condition

Rationale/Basis for Decision

In an effort to reduce pain, reduce tenderness of paraspinal muscles, and stop muscle spasm, various treatment modalities were performed. The patient did not want surgery. Evaluations of the cervical, thoracic, and lumbar spine occurred. The patient underwent manipulation and hypertonicity was elicited. Therapeutic modalities were delivered. It was seen that well into this series of therapeutic application administration, the patient was evaluated for maximum medical improvement status and as of 01/07/03 had not reached this level. It was appropriate to manage the patient's pain in the fashion it was carried out. Therefore, it is determined that the therapeutic procedure, therapeutic activities, and electrical stimulation from 12/06/02 through 01/30/03 were medically necessary.

Sincerely,