MDR Tracking Number: M5-03-2525-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 6-12-03.

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 $460.00** 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 requestor submitted a letter of withdrawal for disputed date of service 9-30-02 (myofascial release only, which was denied as a duplicate charge). The office visits, therapeutic exercises, neuromuscular re-education, myofascial release, aquatic therapy, therapeutic activities were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

The above Findings and Decision are hereby issued this 15th day of September 2003.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

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 7-26-02 through 9-30-02 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 15th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-2525-01

September 3, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
Available information suggests that this patient was injured at work on ___ and reports conditions involving her right knee and cervical spine. The patient eventually underwent right knee surgery, arthroscopy on 5/8/02 and C5/6 cervical fusion on 3/4/02. Following orthopedic knee surgery, treating surgeon,___ recommends post surgical therapy and rehabilitation on 5/21/02. This appears to be performed at a chiropractic facility with ___ and ___. The initial order appears to be for 3x per week for 4 weeks. Orthopedic surgeon renews these orders on 6/27/02, 7/2/02, 7/25/02 and 8/22/02 with specific modifications made due to patient progress. Chiropractic notes are submitted suggesting some significant

progressive improvement through completion of orthopedic orders on 9/30/02. It is noted that the patient has achieved therapy goals, no longer walks with a limp, and is able to resume near normal ADL following treatment. There is a 9/6/02 impairment assessment performed by Farood Selod, MD, suggesting a 17% WP impairment rating combining both cervical spine and knee disorders.

REQUESTED SERVICE(S)
Medical necessity for chiropractic services (Therapeutic procedures, neuromuscular re-education, myofascial release, office visits, aquatic therapy, kinetic activities) for date 7/26/02 through 9/30/02.

DECISION
Reverse prior decision. Medical necessity for services provided during this period is supported by documentation provided.

RATIONALE/BASIS FOR DECISION
Evidence from this file suggests progressive improvement and achieved functional goals with treatment supplied by chiropractic provider and ordered by orthopedic surgeon. Treating surgeon's rehab orders appear to be appropriately followed by chiropractic providers.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute a per se recommendation for specific claims or administrative functions to be made or enforced.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 5th day of September 2003.