MDR Tracking Number: M5-03-2560-01

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 June 6, 2003.

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 Functional Capacity Evaluation and required report were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for Functional Capacity Evaluation and required report charges.

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 date of service 3/20/03 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 26th day of August 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

August 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-2560-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker’s Compensation Commission

(TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he was helping a co-worker lift a heavy toolbox into the back of a pickup. The patient reported that the co-worker dropped his side of the tool box. The patient reported that he felt low back pain when this happened. The patient underwent an MRI on 7/31/02 that showed L4-L5 disc desiccation with posterior disc bulge impinging the thecal sac only and L5-S1 disc desiccation with posterior disc bulge impinging the epidural fat only. The patient was treated with active care including chiropractic adjustments. The patient also underwent an EMG and a Functional Capacity Evaluation on 3/20/03.

Requested Services
Functional Capacity Evaluation and required report on 3/20/03.

Decision
The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision
The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the patient underwent an MRI on 7/31/02 that showed disc desiccation with posterior bulge impinging the epidural fat at the L4-L5 level. The ___ chiropractor reviewer further noted that the treatment for this patient's condition has included active care that included chiropractic adjustments. The ___ chiropractor reviewer indicated that the patient underwent an FCE and required report on 3/20/03. The ___ chiropractor reviewer explained that the FCE the patient underwent on 3/20/03 contains the needed elements (strength testing, range of motion, etc.) in order to assess the physical capability of the patient. The ___ chiropractor reviewer also explained that this information was used to address the patient's ability to retrun to work and at what capacity. Therefore, the ___ chiropractor consultant concluded that the FCE and required report on 3/20/03 was medically necessary to treat this patient's condition.

Sincerely,