

MDR Tracking Number: M5-03-2890-01

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 July 7, 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 \$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 physical therapy and office visits were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the physical therapy and office visit charges.

This Findings and Decision is hereby issued this 12<sup>th</sup> day of November 2003.

Margaret Q. Ojeda  
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 10/1/02 through 1/21/03 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 12<sup>th</sup> day of November 2003.

David R. Martinez, Manager  
Medical Dispute Resolution  
Medical Review Division

DRM/mqo

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

November 4, 2003

**Re: IRO Case # M5-03-2890**

Texas Worker's Compensation Commission:

\_\_\_ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to \_\_\_ for an independent review. \_\_\_ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, \_\_\_ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Physical Medicine and Rehabilitation, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting 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 referral to \_\_\_ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the \_\_\_ reviewer who reviewed this case, based on the medical records provided, is as follows:

### History

The patient is a 50-year-old male who on \_\_\_ was lifting a heavy object from the ground and felt an acute onset of lower back pain that increased throughout the day. He was given medication and on 8/19/02 was started on physical therapy. A 9/4/02 MRI of the lumbar spine was significant for multiple degenerative anomalies and multi-level degenerative disks, without true central disk protrusion or central canal stenosis. Physical therapy continued until 1/21/03.

### Requested Service(s)

Physical therapy and office visits 10/1/02-1/21/03

### Decision

I disagree with the carrier's decision to deny the requested treatment.

### Rational

The patient was appropriately started in physical therapy on 8/19/02. He progressed from aquatic therapy on to land-based exercises. The patient progressed slowly, but there is documentation of improvement in range of motion and pain. The patient was eventually able to return to work on a light duty basis at the completion of the physical therapy program. The treatment was appropriate and medically necessary.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.