MDR Tracking Number: M5-03-3011-01

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 21, 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 therapeutic activities and exercises, office visits, electrical stimulation, hot/cold packs were found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the therapeutic activities and exercises, office visits, electrical stimulation, hot/cold packs 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 dates of service 10/14/02 through 1/31/03 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 12th day of September 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M5-03-3011-01

September 10, 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

___ was injured at work on ___ while lifting a hot water heater. He felt a pulling sensation in his lower back and the symptoms continued to worsen with radiation into his lower extremities. He initially went to the emergency room where he received x-rays and started rehab; however this rehab was halted. ___ started rehab with ___on 10/2/02.

REQUESTED SERVICE(S)

Therapeutic activities and exercises, office visits, electrical stimulation, hot/cold packs for dates of service 10/14/02 through 1/31/03.

DECISION

All the services are warranted and medically necessary for rehab of this injury.

RATIONALE/BASIS FOR DECISION

From reviewing the records received, it shows the carrier started to pay for the initial 6 treatments and then reduced payment based on treatment exceeding medically accepted utilization. ___ had a large lapse in treatment from the date of his initial injury until he reached ___ office. During this time frame he continually worsened based on records reviewed. The rehab program designed for him at ___ office was medically necessary for the injury. This involved factoring in the mechanism of injury and time frame of original date of injury. When starting a rehab program of this nature, the patient will be expected to perform more active rehab as the program initially progresses. Reducing treatment after 6 visits would be an ineffective plan of care due to the nature of this injury. As for the re-evaluations questioned, these must be performed in order to monitor progress and modify the treatment plan. Texas Labor Code states than an injured worker is entitled to reasonable medical treatment that relieves his symptoms. ___ suffered for 6 months with no relief based on the records reviewed. With 4 months of care with ___ office, ___ returned to work. This was an effective rehab program, especially considering the initial lapse in treatment in which the patient continually worsened.

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 11th day of September 2003.