MDR Tracking Number: M5-02-1993-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 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(q)(9), the Commission hereby orders the respondent (non-prevailing party) to **refund the requestor $460.00** for the paid IRO fee.

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 office visits with manipulation were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the office visits with manipulation 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 from 2-2-01 through 2-27-01 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 1st day of July 2002.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
DZT/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

May 30, 2002

Texas Workers' Compensation Commission

Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: MDR #: M5-02-1993-01
IRO Certificate No.: 5055

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Doctor of Chiropractor, D.C.C.C.

THE PHYSICIAN REVIEWER OF THIS CASE **DISAGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

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

If disputing a spinal surgery prospective decision a request for a hearing must in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 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 Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile of U.S. Postal Service from the office of the IRO on May 30, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is ___ D.C. for ___. I have reviewed the medical information forwarded to me concerning TWCC Case File # M5-02-1993-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. TWCC IRO Assignment dated 1/23/02, one page.
2. TWCC #60, Medical Dispute Resolution Request/Response dated 2/04/02, 2 pages.
3. TWCC #60, Table of Disputed Services from 02/02/01 through 02/27/01, one page.
4. ___ of Benefits dated 07/24/01 for office visits from 02/02/01 through 02/27/01.
5. Computer printout, assumed to be from ___, and does not appear to be directly related to this claim.
6. ___ letter citing TWCC rules and regulations supporting payment of claim submitted, dated 04/26/02, 8 pages.
7. ___ request for reconsideration, dated 05/09/01 one page.
8. ___ letter of appeal for payment, dated 04/23/01, one page.
9. ___ letter of appeal for payment, dated 04/24/02, four pages.
10. ___ letter dated 05/19/00, one page.
11. ___ written communication report from 01/05/00 through 06/26/01.
12. ___ pre-authorization request dated 12/18/99, 2 pages.
13. ___'s response to pre-authorization request, dated 12/24/99, one page.
14. ___'s response to pre-authorization request, dated 12/28/99, one page.
15. ___, D.C., office notes dated 02/02/01 through 02/27/01.
16. ___ report dated 04/11/00, one page.
17. ___ report dated 02/21/00, 3 pages.
18. ___ report dated 05/04/00, 2 pages.
19. ___ impairment rating report, dated 05/09/00, 3 pages.
20. ___ TWCC-69 report and TWCC-73 report dated 05/09/00, 2 pages.
21. ___ letter dated 12/16/99, one page.
22. ___ MRI report, lumbar spine, dated 11/02/99, 2 pages
23. ___ lumbar spine x-ray report, dated 11/02/99, one page.
24. Nerve conduction study dated 10/05/99, 2 pages.
25. ___ MRI report of the lumbar spine, dated 07/05/00, 2 pages.

26. ___ lumbar spine x-ray report, dated 07/05/00, one page.
27. ___ designated doctor impairment rating report, dated 07/07/00, 4 pages.

B. SUMMARY OF EVENTS:

___ incurred a lower back injury at work on ___. The records indicate that he is a 60-year-old male who was employed as a laborer. Apparently, his lower back injury resulted from lifting bundles of steel rods. Symptoms included lower back pain and radiating pains down the leg to his toes. Subsequent MRI reports indicate disk bulges at L1/L2, L2/L3,L3/L4, L4/L5, and L5/S1. Treatment has included conservative care from his treating physician/chiropractor, ___ and nerve root injections.

The review is for medical dispute for nonpayment of office visits for the month of February 2001 rendered by his treating physician.

C. OPINION:

I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

The treating physician has provided documentation citing TWCC rules and regulations governing treatment of the injured employee, supporting the claim for payment of office visits. The treating physician's office notes provide supporting clinical information, which supports medical necessity of care and improvement in response to receiving the care.

The Texas Fund did not provide any information supporting their position for denial of rendered services. The Explanation of Benefits reviewed only indicates the carrier's position that " the documentation submitted does not support the medical necessity of the treatment/service performed."

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, completed and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.