

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

**SOAH DOCKET NO. 453-03-2743.M5**

MDR Tracking Number: M5-02-2198-01

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 did not prevail** on the majority of issues of medical necessity. Therefore, the requestor is not entitled to reimbursement of the 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, codes 97032, 97010 and 97035 on date of service 9/6/01, were found to be medically necessary. The physical therapy and office visits for the remaining dates of service, 8/21/01 through 9/7/01 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these physical therapy 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 8/21/01 through 9/7/01 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 14<sup>th</sup> day of February 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

January 14, 2003

**Re: IRO Case # M5-02-2198-01**

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 physician who is Board Certified in Physical Medicine and Rehabilitation. 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 37-year-old female injured \_\_\_ when boxes fell on her, knocking her to the ground. She suffered head, neck and back injuries. She was diagnosed with a concussion and cervical and lumbar strain/sprain. She was given medication and x-rays were taken of the neck, thoracic and lumbar spine. The x-rays were negative for fracture or deformity. An MRI 8/28/01 was severely compromised by an artifact, but did show straightening of the normal cervical lordosis with a mild kyphosis at C4 and C5 and mild narrowing of the subarachnoid space. The work up also included neuroconnection studies 9/6/01, which were significant for only mild right carpal tunnel syndrome, but negative for radiculopathy. The patient received extensive daily chiropractic treatment and passive modalities.

Requested Service

Chiropractic treatment 8/21/01–9/7/01.

Decision

I agree with the carrier's decision to deny the services 8/21/01, 8/23/01, 8/28/01, 8/30/01, 9/5/01, 9/7/01 and the office visit 9/6/01

I disagree with the carrier's decision to deny the services 9/6/01, codes 97032, 97010, 97035.

Rationale

Following the \_\_\_ injury the patient was seen daily for two weeks. Daily care would not be reasonable and necessary in this case. Five other office visits and treatments were already approved for this period. During the third week following the injury, from 9/5/01-9/7/01 there is no documentation of the office visits. The subnotes submitted for those dates are blank. The services provided 9/6/01 are reasonable in the treatment of the patient's injury.

This medical necessity decision by an Independent Review Organization 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 the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (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 Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,