

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 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 psychiatric interview, individual psychotherapy, physical therapy, work hardening program, required reports, FCE and office visits were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 8<sup>th</sup> day of November 2002.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review

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 7/5/01 through 9/11/01 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 8<sup>th</sup> day of November 2002.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/nlb

October 29, 2003

Re: Medical Dispute Resolution  
MDR #: M5.02.2814.01  
IRO Certificate No.: IRO 5055

Dear :

\_\_\_ has performed an independent review of the medical records of the above-named case 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. This case was reviewed by a physician who is certified in Chiropractic medicine.

Clinical History:

This claimant is a 36-year-old male who sustained an on-the-job injury on \_\_\_, while lifting a box weighing approximately 100 lbs. A lumbar MRI on 01.03.01 revealed several areas of lumbar disk involvement. An FCE and EMG/NCV over the following months suggested lumbosacral radiculopathy. Over the course of treatment referrals to specialists were performed which indicated prescription medication was warranted, and additional therapy was needed. Subsequent treatment and evaluations revealed the patient continued to experience ongoing problems, including anxiety and depression as a result of this injury.

Disputed Services:

Office visit (09.11.01), psychological interview (07.05.01), therapy (07.18.01, 07.24.01, 08.30.01, 08.09.01, 08.17.01, 08.23.01, 08.27/01, FCE (09.06.01), work hardening (07.18.01 through 08.31.01), and TWCC-73s (08.02.01 and 09.04.01)

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the services, treatments and therapies as listed for the period 07.05.01 through 09.11.01 were medically necessary in this case.

Rationale for Decision:

It is the professional opinion of the reviewer that based upon *TWCC Rules and Guidelines* for work hardening programs that were in effect at the time these services were rendered, the appropriate treatment protocol for his patient was followed. In addition, the reviewer determined that all disputed

services a indicated above were, in fact, reasonable and medically necessary in an attempt to return this patient to his former job classification and to progress toward maximum medical improvement.

I am the Secretary and General Counsel of \_\_\_\_ and I certify that the reviewing healthcare professional 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.