

MDR Tracking Number: M5-02-2824-01

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 and 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, physical therapy and FCE were found to be medically necessary. The respondent raised no other reasons for denying reimbursement charges for the office visits, physical therapy and FCE.

This Finding and Decision is hereby issued this 14<sup>th</sup> day of October 2002.

Carol R. Lawrence  
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 8/24/01 through 12/28/01 in this dispute and IRO fee.

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 October 2002.

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

DRM/crl

October 7, 2002

Re: Medical Dispute Resolution  
MDR #: M5.02.2824.01  
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. Your case was reviewed by a physician who is Certified in Chiropractic Neurology.

The physician reviewer **DISAGREES** with the determination of the insurance carrier in this case. The reviewer is of the opinion that the office visits, physical therapy and FCE from 08.24.01 through 12.28.01 **were medically necessary**.

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.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_. I have reviewed the medical information forwarded to me concerning MDR #M5-02-2824-01, in the area of Chiropractic Neurology. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of office visits, physical therapy, and FCE from 08/24/01 through 12/28/01.
2. Correspondence.
3. Office notes.
4. Physical therapy and work hardening notes.
5. Functional Capacity Evaluation.

B. BRIEF CLINICAL HISTORY:

The patient sustained a work-related injury on \_\_\_\_\_. The injury was described as a pushing injury in which she was asked to push a cart weighing 300 pounds. Her employer at the time was \_\_\_\_\_. She was examined by \_\_\_\_\_ on April 1, 2001, and was given the diagnosis of 839.20, Lumbar subluxation; 847.2, Lumbar sprain/strain; 722.73, Lumbar IVD disease with myelopathy; and 724.4, Lumbar radiculopathy. After she reviewed an MRI and NCV, her diagnosis was changed to 722.73, Lumbar IVD disorder with myopathy; 724.4, Lumbar radiculopathy; 839.2, Lumbar subluxation; and 847.2, Lumbar sprain/strain.

C. DISPUTED SERVICES:

Office visits, physical therapy, and FCE from 08/24/01 through 12/28/01.

D. DECISION:

I disagree with the decision to deny approval of the various dates of service for \_\_\_\_\_.

E. RATIONALE OR BASIS FOR DECISION:

After careful review of the above-stated medical records, it is my determination that the compensable injury received the correct amount of care from the treating physician. The diagnostic procedures performed, as documented, were above and beyond a simple sprain/strain. The course of the physical therapy and work hardening was correctly documented to show the efficiency of the care. The fact that the patient was now returned to work amplifies the beneficial factor of work hardening. The patient's office visits were also medically necessary and carefully documented to exhibit the progress of the patient in the general course of treatment. In addition, the doctor carefully documented all pre-authorization codes for his physical therapy sessions.

F. 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, complete 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.

I certify that I have no past or present relationship with the patient and no significant past or present relationship with the attending physician. I further certify that there is no professional, familial, financial, or other affiliation, relationship, or interest with the developer or manufacturer of the principal drug, device, procedure, or other treatment being recommended for the patient whose treatment is the subject of this review. Any affiliation that I may have with this insurance carrier, or as a participating provider in this insurance carrier's network, at no time constitutes more than 10% of my gross annual income.