

MDR Tracking Number: M5-02-2855-01

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, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of 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 FCE on 11/21/01 was found to be medically necessary. The office visits and work hardening were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for this FCE charge.

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 7/30/01 through 11/21/01 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 5th day of February 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

January 6, 2003

REVISED

Texas Workers' Compensation Commission
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

Re: Medical Dispute Resolution
MDR#: M5-02-2855-01
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 male claimant was injured on his job on ____. MRI of the lumbar spine revealed an L4-5 disc protrusion and minimal degenerative changes noted at L1-2. The patient began treatment on 10/10/00.

Disputed Services:

Office visits from 07/30/01 through 09/24/01, office visits with manipulations from 12/10/01 through 12/17/01, and an FCE on 11/21/01.

Decision:

The reviewer partially agrees with the determination of the insurance carrier. The reviewer is of the opinion that the office visits, and the office visits with manipulations during the period indicated **were not medically necessary**. The Functional Capacity Evaluation on 11/21/01 **was medically necessary**.

Rationale for Decision:

Documentation was not presented that would warrant the application of further interdisciplinary therapeutic applications over

the treatment period reviewed. The patient had been treated for nine months. Further conservative applications are not appropriate and are not necessary to treat this patient' condition.

The Unremitting Low Back Pain: North American Spine Society Phase III Clinical Guidelines for Multi-Disciplinary Spine Care Specialists, show that the initial phase of specialized care (non-operative interventions) and secondary phase of specialized care (non-operative interventions) should last eight months. The patient has shown failure in the primary and secondary phases of care. Further applications in these phases of care are not appropriate to treat this patient's condition.

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 who reviewed this case for determination prior to referral to the Independent Review Organization.

Sincerely,