

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

SOAH DOCKET NO.: 453-03-2248.M5

MDR Tracking Number: M5-02-2877-01

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

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 2/6/02 through 2/25/02 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 3rd day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

September 24, 2002

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M5 02 2877 01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

The documentation states ___ on ___ was lifting a 200 lb. Concrete stone and injured his low back. The patient initially sought care at ___ with ___. ___ was released that day with medications, three days of physical therapy and a modified job description for his employer. The patient was unhappy with the treatment provided and sought care with ___ for his condition. The documentation does show ___ has a Pars defect at L5 but the documentation does not state if the spondylolysis is slipped or stable. An MRI performed on 1/31/2002 displayed a 4-5 mm discopathy with no neurogenic compromise. The documentation provided shows the carrier denying physical therapy services within the first 8 weeks of care due to "treatment exceeds medically accepted utilization review."

DECISION

The reviewer disagrees with the carrier's prior adverse determination for all of the treatment disputed.

BASIS FOR THE DECISION

The adopted medical fee guidelines effective 4/1/1996 clearly state the exclusive use of physical medicine modalities is limited to a maximum of 2 weeks unless documentation is provided substantiating the need for continued use of these modalities. ___ did display a positive response from the treatment provided and therefore would be considered compensable. The treatment provided falls within the Mercy Guidelines, TCA Guidelines for Chiropractic Quality Assurance and Practice Parameters and within the Spinal Treatment Guidelines (in effect at the time of injury).

As an officer ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,