

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 chiropractic treatment with therapy was found to be medically necessary 10/3/01 through 11/8/01, 11/26/01 through 11/29/01, 1/24/02, 1/28/02, 1/29/02 and 5/6/02. The respondent raised no other reasons for denying reimbursement for the chiropractic treatment with therapy charges.

This Finding and Decision is hereby issued this 3rd day of January 2003.

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 10/3/01 through 5/6/02 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 January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/cl

October 22, 2002

CORRECTED

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

MDR Tracking #: M5 02 3066 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.

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

___ injured his low back in a work accident on ___. He was injured while trying to tilt a ceiling head which weighed approximately 500-700 pounds. He has undergone a variety of treatments including medicines, physical therapy, exercise, epidural steroid injections and chiropractic manipulation. A MRI dated February 10, 2000 revealed no herniated nucleus pulposus and mild degenerative joint disease at L5-S1, along with minimal changes at L3-L4 and L4-L5. The patient had an impairment rating on November 8, 2001 by ___ and his treating doctor ___ agreed with the MMI and assigned impairment of 6%. It appears that the carrier has denied all chiropractic care after October 1, 2001 as being not reasonable or necessary. The patient began chiropractic care on September 19, 2001.

DISPUTED SERVICES

Physical medicine and chiropractic treatment from October 3, 2001 through May 6, 2002.

DECISION

The reviewer partially agrees and partially disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Utilizing the Mercy Guidelines and the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, the care this patient received up to the date of 11/8/2001 is both reasonable and necessary. After that date the patient would discontinue any type of active treatment program. After 11/8/2001, treatment for exacerbations of symptoms would be appropriate. There is evidence of exacerbation on 11/26/2001, 11/27/2001, 11/29/2001, 1/24/2002, 1/28/2002, 1/29/2002 and 5/6/2002.

As an officer of ____, 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,