

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 disputed office visits, office visits with manipulations, physical therapy and bio-freeze were found to be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Finding and Decision is hereby issued this 31<sup>st</sup> day of January 2003.

Noel L. Beavers  
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 2/8/02 through 4/9/02.

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 31<sup>st</sup> day of January 2003.

Roy Lewis, Supervisor  
Medical Dispute Resolution Officer  
Medical Review Division

RL/nlb

January 13, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-0820-01**

\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). \_\_\_ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to \_\_\_ for independent review in accordance with this Rule.

\_\_\_ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on \_\_\_ external review panel. \_\_\_ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to \_\_\_ for independent review. In addition, \_\_\_ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 25 year-old female who sustained a work related injury on \_\_\_. The patient reports that while lifting a box of unknown weight, she felt right-sided S1 and low back pain. The patient had an X-Ray and was treated with steroidal anti-inflammatories and muscle relaxants. The patient also had an MRI that showed a posterior central L5-S1 herniation measuring 5mm resulting in ventral thecal sac and bilateral S1 nerve contact. The patient also had electro-diagnostic studies performed. The patient was further treated with physical therapy, heat and water therapy, and oral pain medications.

### Requested Services

Office visits, office visits with manipulations, physical therapy and bio freeze from 2/8/02 through 4/9/02.

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

### Rationale/Basis for Decision

\_\_\_ chiropractor reviewer concluded that the office visits, office visits with manipulations, physical therapy and bio freeze rendered from 2/8/02 through 4/9/02, were medically necessary to treat this patient's condition. \_\_\_ chiropractor reviewer explained that a herniated disc with

thecal sac deformity should be allowed that amount of time to heal. \_\_\_ chiropractor reviewer also explained that the injury suffered by this patient could require multiple forms of treatment. \_\_\_ chiropractor reviewer further explained that the 2 ½ months this patient required to recover from the herniated disc injury sustained on \_\_\_, is considered a short recovery period. Therefore, \_\_\_ chiropractor consultant concluded that the office visits, office visits with manipulations, physical therapy and bio freeze rendered from 2/8/02 through 4/9/02 was medically necessary to treat this patient's condition.

Sincerely,

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