

MDR Tracking Number: M5-04-0066-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on September 3, 2003.

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(r)(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 myofascial release, electrical stimulation, work hardening and functional capacity evaluation was found to be medically necessary. The respondent raised no other reasons for denying reimbursement of the myofascial release, electrical stimulation, work hardening and functional capacity evaluation charges.

This Findings and Decision is hereby issued this 14<sup>th</sup> day of November 2003.

Margaret Q. Ojeda  
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 11/20/02 through 1/30/03 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 14<sup>th</sup> day of November 2003.

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

**NOTICE OF INDEPENDENT REVIEW DETERMINATION**

**REVISED 11/7/03**

MDR Tracking Number: M5-04-0066-01

October 31, 2003

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by \_\_\_\_, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

\_\_\_ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to \_\_\_.

Notice of Independent Review Determination

CLINICAL HISTORY

On \_\_\_\_, \_\_\_ was involved in a motor vehicle accident in which he struck a vehicle that had pulled out in front of him. He noticed immediate symptoms following the accident.

REQUESTED SERVICE(S)

Myofascial exercises, stimulation, work hardening FCAP performance on dates 11/20/02 through 1/30/03.

## DECISION

Treatment is within normal limits and is warranted for patient's recovery.

## RATIONALE/BASIS FOR DECISION

On October 11, 2002 \_\_\_ presented to \_\_\_ with symptoms that were rated from level 5 to 8 on the 0-10 pain scale. There were two major factors in the amount of force his body absorbed. 1) his small stature; and 2) he was wearing a seat belt that was not broken upon impact. Both of these elements allow for more force from the impact to be translated into the occupants body. Based on the information contained in the recently released 3<sup>rd</sup> Edition of Whiplash Injuries by Foreman and Croft, who are considered to be the foremost experts in this field of research, \_\_\_ treatment plan, timing and usage of the treatment protocol was textbook perfect. Based on the subjective and objective improvement noted in the FCE's performed 11/25/02, 12/23/02 and 1/30/03 it would appear that this patient was recovering from his injuries and able to return to a more normal lifestyle. TX Labor Code notes that a patient is entitled to all reasonable care that cures or relieves the effects of the injury, promotes recovery and enhances the ability of the employee to return to or retain employment. Based on the information received, this is the case for this patient and would be considered a very successful recovery.

## **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk  
Texas Workers' Compensation Commission  
P.O. Box 17787  
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 7<sup>th</sup> day of November 2003.