

MDR Tracking Number: M5-04-0574-01

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 October 17, 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(q)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** 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 office visits, therapeutic exercises, unlisted therapeutic activities, joint mobilization, ultrasound therapy, electrical stimulation, and myofascial release were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This findings and decision is hereby issued this 6<sup>th</sup> day of January 2004.

Patricia Rodriguez  
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 12/16/02 through 01/30/03 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 6<sup>th</sup> day of January 2004.

Roy Lewis, Supervisor  
Medical Dispute Resolution  
Medical Review Division

RL/pr

December 24, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-04-0574-01**

\_\_\_ 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 the \_\_\_ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The \_\_\_ 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, the \_\_\_ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 40 year-old male who sustained a work-related injury on \_\_\_. The patient reported that while at work, he attempted to exit his truck that was stuck in the mud, through the window when he fell causing injury to his head, neck and back. The patient underwent X-Rays of the lumbar spine in the emergency room and had also undergone cervical spine X-Rays on 9/18/02. The patient underwent a MRI dated 9/18/02 that showed left L5-S1 disc herniation. A CT scan of the head was reported as unremarkable and a repeat head CT scan dated 10/9/02 showed ethmoid sinusitis. On 11/18/02 the patient underwent an epidurogram, epiduroscopy and decompressive neuroplasty. On 12/20/02 the patient underwent a MRI of the cervical spine that showed minimal degenerative disc changes at C4-5, C5-6 and moderate changes at the C7-T1 and T1-T2. The diagnoses for this patient have included lumbar intervertebral disc disorder without myelopathy, acute cervical and lumbar strain and sprain, and post traumatic headaches. Treatment for this patient has included interferential and heat, myofascial releat, joint mobilization, ultrasound and therapeutic exercise.

### Requested Services

Office visit, therapeutic exercises, unlisted therapeutic procedure, therapeutic activities, joint mobilization, ultrasound therapy, electric stimulation, myofascial release from 12/16/02 through 1/30/03.

### 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

The \_\_\_ chiropractor reviewer noted that this case concerns a 40 year-old male who sustained a work related injury to his head, neck and back. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar intervertebral disc disorder without myelopathy, acute cervical and lumbar strain and sprain, and post traumatic headaches. The \_\_\_ chiropractor reviewer further noted that treatment for this patient has included interferential and heat, myofascial release, joint mobilization, ultrasound and therapeutic exercises. The \_\_\_ chiropractor reviewer explained that the treatment this patient received was appropriate for the nature of this patient's injury. The \_\_\_ chiropractor reviewer also explained that the patient responded reasonably well to the treatment rendered. Therefore, the \_\_\_ chiropractor consultant concluded that the office visit, therapeutic exercises, unlisted therapeutic procedure, therapeutic activities, joint mobilization, ultrasound therapy, electric stimulation, myofascial release from 12/16/02 through 1/30/03 were medically necessary to treat this patient's condition.

Sincerely,