

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

**SOAH DOCKET NO. 453-04-6506.M5**

MDR Tracking Number: M5-04-2074-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-10-04.

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** 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 visit and special report were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

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 date of service 1/06/04 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 Decision and Order is hereby issued this 4<sup>th</sup> day of May 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division  
RLC/rlc

April 26, 2004

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

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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 reviewer is on the TWCC Approved Doctor List (ADL). 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 her neck, left shoulder, lower back and both knees on \_\_\_ when she fell on the sidewalk, hitting both knees. She sustained her body with her left arm/hand to prevent hitting her face. She developed pain in her mid back, lower back, left groin area, left wrist/hand and left shoulder. She has confirmed MRI evidence of small midline protrusions of 2 mm each at L4/5 and L5/S1. She has MRI evidence of right knee medial meniscus tear and MRI evidence of left knee medial meniscus tear. An MRI of the left shoulder reveals moderate impingement and AC DJD. She has undergone BRC and CCH for compensability, finalized on 01/23/04. Parties agreed to compensable loss of incomplete rotator cuff tear of the left shoulder, impingement of left shoulder, tear of the posterior horn of medial meniscus of right knee, tear of posterior horn of the medial meniscus of the left knee and lumbar sprain/strain and disc protrusions at L4/5 and a cervical sprain/strain.

#### DISPUTED SERVICES

Under dispute is the medical necessity of an office visit and special reports.

#### DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

First, \_\_\_ was selected by the patient as the primary treating doctor. This was approved by TWCC. The patient is entitled to the necessary evaluations performed by \_\_\_\_\_. Obviously, this patient has ongoing, non-resolved medical issues that require evaluation and management. Certainly, a baseline evaluation to determine further management needs is mandatory and necessary. Secondly, the TWCC required Work Status form is a required form for \_\_\_ to be in compliance with TWCC rules.

\_\_\_ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. \_\_\_ has made no determinations regarding benefits available under the injured employee's policy

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,