

MDR Tracking Number: M5-04-2286-01

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 3-23-04.

The following disputed dates of service were withdrawn by the requestor on June 23, 2004 and therefore will not be addressed in this Decision: 3/25/03, 7/03/03 (CPT code 98941 only).

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 visits with manipulation, electrical stimulation (unattended), mechanical traction, ultrasound, and chiropractic manipulative treatments (3-4 regions) from 5/8/03 through 10/29/03 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 dates of service 5/8/03 through 10/29/03 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 Decision and Order is hereby issued this 28<sup>th</sup> day of June 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

RLC/rlc

June 4, 2004

## NOTICE OF INDEPENDENT REVIEW DECISION

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\_\_\_ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The \_\_\_ 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 who is familiar with the with the condition and treatment options at issue in this appeal. 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 male who sustained a work related injury on \_\_\_. The patient reported that while at work he injured his low back and left hip when he stepped out of his tractor into a hole. The diagnoses for this patient have included cervical sprain/strain, thoracic sprain/strain, and lumbar sprain/strain. The patient had been treated conservatively through 1/14/03 and released from care. The patient returned for further treatment in 3/03 due to an exacerbation in his condition and was released after two treatment sessions. On 5/8/03 the patient returned again for further treatment due to an exacerbation in his condition and was treated with electrical stimulation, mechanical traction, ultrasound and chiropractic manipulation treatments.

#### Requested Services

Review of report, level III established patient office visits with manips, electrical stimulation unattended, mechanical traction, ultrasound, chiropractic manipulative treatment (3-4 regions) from 5/8/03 through 10/29/03.

#### Documents and/or information used by the reviewer to reach a decision:

##### *Documents Submitted by Requestor:*

1. Chiropractic Modality Review 5/4/03
2. SOAP notes 10/17/02, 5/8/03 – 10/29/03

##### *Documents Submitted by Respondent:*

1. No documents submitted

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 male who sustained a work related injury to his low back and left hip on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the diagnoses for this patient have included cervical sprain/strain, thoracic sprain/strain, and lumbar sprain/strain. The \_\_\_ chiropractor reviewer further noted that the patient had begun treatment on 5/8/03 for an exacerbation of his condition. The \_\_\_ chiropractor reviewer indicated that this patient had a condition that was periodically exacerbated by the work he was performing. The \_\_\_ chiropractor reviewer noted that the patient would receive care to relieve his pain and remain in the work force. The \_\_\_ chiropractor reviewer explained that the treatment this patient received was appropriate, medically necessary, and followed the TWCC rules of relieving pain and allowing the patient to remain in the work force. Therefore, the \_\_\_ chiropractor consultant concluded that the review of report, level III established patient office visits with manip, electrical stimulation unattended, mechanical traction, ultrasound, chiropractic manipulative treatment (3-4 regions) from 5/8/03 through 10/29/03 were medically necessary to treat this patient's condition.

Sincerely,