

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:
SOAH DOCKET NO. 453-04-8358.M5**

MDR Tracking Number: M5-04-2315-01

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 3-25-04.

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 visits, manual therapy, neuromuscular re-education, and therapeutic exercises from 11/11/03 through 12/30/03 were found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

This Findings and Decision is hereby issued this 7th day of July 2004.

Regina L. Cleave
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 11/11/03 through 12/30/03 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 7th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/rlc

June 14, 2004

MDR Tracking #: M5-04-2315-01
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

___ sustained a lumbar injury while working as a service man at ___. An MRI was performed on November 24, 2003 that revealed multilevel disc bulges ranging from L3-L5, with a Schmorl's node at the superior endplate of L5. The patient underwent conservative care under the direction of ___ with improvement noted in his condition. The patient's file was reviewed early on by ___, who determined that ___ suffered a minor sprain/strain and should have returned to work within two weeks, even though all examination findings were suggestive of a disc injury. Once the MRI was completed and the extent of the patient's injury confirmed, ___ did not change his opinion.

DISPUTED SERVICES

Under dispute is the medical necessity of office visits manual therapy, neuromuscular re-education and therapeutic exercises provided from 11/11/03 through 12/30/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Upon review of this patient's record, the treating doctor appropriately made a referral for an MRI in a timely manner. The conservative care rendered ___ in the form of office visits, manual therapy, neuromuscular re-education and therapeutic exercises were utilized to bring his case to a successful conclusion. All services and activities are properly documented and include subjective as well as objective notations in response to the treatment. This treatment was reasonable and necessary, as it was designed to increase function and relieve symptoms so he could return to

gainful employment. The TWCC Medicine Ground Rules state on page 31, 1(A) 2 that the treatment in question should be “specific to the injury and provide potential improvement of the patient’s condition.” ___ treatment was medically necessary as it was intended to “cure or relieve” the symptoms resulting from the compensable injury as outlined in the Texas Workers’ Act, section 401.001(31) and should be paid according to the Medical Fee Guidelines.

___ 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 ___, Inc, dba ___, 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,