MDR Tracking Number: M5-03-0001-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective January 1, 2002 and Commission Rule 133.305 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 Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Chiropractic care (including office visits including physical and therapeutic therapies) rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that Chiropractic care fees were the only fees involved in the medical dispute to be resolved. As the treatment, (Chiropractic care) was not found to be medically necessary, reimbursement for dates of service from 9/21/01 through 4/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 20th day of November 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 18, 2002

Re: IRO Case # M5-03-0001-01

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IRO's, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic who is licensed by the State of Texas. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient was injured in ___ while filling and stacking boxes. She was diagnosed with abdominal herniation and lumbar sprain/strain. She was treated for low back pain. She also had a hernia repair.

Requested Service(s)

Chiropractic care 9/21/01 – 4/12/02

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The documentation provided fails to show the need for chiropractic treatment. The complaints of low back pain are without objective findings of any neurologic deficit or injury to the spine. The documentation fails to show progress over several months of treatment. The documentation also fails to show objectively measured and demonstrated functional gains. There is nothing objective in the documentation provided for review to justify any of the disputed services. The documentation fails to provide a rationale for the disputed treatment.
The patient was involved in two injuries after her work injury. It is possible that these two injuries are the reason for further treatment of the patient's lower back pain. Documentation of these two accidents fails to explore the effect on the original lower back injury. It is reported that the patient demonstrated numerous Waddell signs, which bring into question the reliability of her subjective complaints.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

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. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) 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 (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

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

Sincerely,