

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, in accordance with §133.308(q)(9), the Commission **Declines to Order** the respondent to refund the requestor for the paid IRO fee.

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 chiropractic treatment was not found to be medically necessary. The respondent raised no other reasons for denying reimbursement. This decision applies to dates of service 8/17/01 through 3/22/02.

This Finding and Decision is hereby issued this 17th day of December 2002.

Noel L. Beavers  
Medical Dispute Resolution Officer  
Medical Review Division

NLB/nlb

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

December 7, 2002

**Re: IRO Case # M5-03-0048**

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, Rule 133.308 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 IROs, 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 and who also is a Certified Strength and Conditioning Specialist. 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 injured his low back in \_\_\_ when he leaned over a belt and picked up an object weighing approximately ten pounds. He sought the care of a chiropractor in March, 2001, and chiropractic care was initiated.

Requested Service

Chiropractic treatment 8/17/01 3/22/02

Decision

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

Rationale

The patient received extensive chiropractic treatment and injections with little, if any, relief of symptoms. A work hardening program was also of little benefit. The documentation presented for review does not show resolution of symptoms after the extensive treatment and fails to support the necessity for the treatment under dispute. Following several months of chiropractic treatment, an evaluation on 7/30/01 still indicated several positive orthopedic tests, restricted lumbar range of motion and muscle spasm.

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,