MAXIMUS

November 14, 2002

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-0122-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------- Case #:

------- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). -------' IRO Certificate Number is -----. 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 and licensed chiropractor on -------'s external review panel. -------'s chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this physician 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, -------'s chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old female who experienced the onset of upper back and neck pain while at work on -------. She underwent a cervical fusion in 1997. She has also received passive and active therapy, epidural steroid injections, pain management treatment and medications. The member underwent manipulation under anesthesia on 1/22/02, 1/23/02, 1/25/02, 1/28/02 and 1/29/02 and received follow-up services.

Requested Services

Office visits and physical therapy from 2/28/02 to 4/24/02 denied as being medically unnecessary.

Decision

The Carrier's denial of coverage for these treatment services is overturned.

Rationale/Basis for Decision

-------'s chiropractor reviewer explained that there is no significant documented research that addresses the issue of whether post-manipulation under anesthesia is necessary. -------'s chiropractor reviewer noted that there are studies that conclude that such treatment is necessary and other studies that conclude that it is not necessary. -------'s chiropractor reviewer explained that because no major study exists to help define the efficacy of this procedure and follow-up therapy, this is primarily done on a clinical basis. -------'s chiropractor consultant indicated that this patient was treated with a specific course of treatment following manipulation under anesthesia and that this treatment was successful for her. -------'s chiropractor consultant noted that she is no longer under actual care. -------'s chiropractor consultant explained that this treatment was significant in finally abating a fair amount of her symptoms. Therefore, -------'s chiropractor consultant concluded that these services were medically necessary for treatment of the patient's condition.

Sincerely,

Project Manager, State Appeals