MDR Tracking Number: M5-03-0320-01

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 treatment (including office visits, report, x-ray exam, physical therapy and supplies) were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that chiropractic treatment fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 1/10/02 to 2/11/02 is denied and the Division declines to issue an Order in this dispute.

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

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

December 7, 2002

Re: IRO Case # M5-03-0320

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 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. 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 ___ when his right hand was caught in a machine. He was diagnosed with an open wound of the finger, fracture of the metacarpal bone, wrist and hand sprain.

Requested Service
Chiropractic treatment 1/10/02 through 2/11/02

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

Rationale
None of the disputed treatment given to the patient was medically necessary or appropriate. Treatment of a fracture or open wound is beyond the scope of practice for chiropractors in Texas. The wrist and hand sprain are within the scope of practice for chiropractors in Texas, but given the other diagnoses in this case, the patient should have been treated by a hand specialist.

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

Sincerely,