MDR Tracking Number: M5-03-0459-01

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 chiropractic treatment including therapeutic procedures was not medically necessary. Date of service 3/1/02 was documented paid, therefore no longer part of this dispute. 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 including therapeutic procedure 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 3/1/02 to 9/4/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of April 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 10, 2003

Re: IRO Case # M5-03-0459

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 is a 37-year-old male injured on ___ when he slipped and fell, twisting his left knee. Knee surgery was performed 3/7/02. Post operative therapy with a chiropractor began 3/22/02. The patient received 60 post op physical therapy visits from 3/22/02 through 9/18/02.

Requested Service
Chiropractic treatment 5/2/02 through 9/4/02

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

Rationale
The patient received extensive therapy prior to his surgery without good results. An MRI should have been performed much earlier in his treatment program rather than waiting some three months post-injury and going through therapy that was yielding little response prior to the 3/7/02 surgery. Four weeks of post-op therapy is usual and customary. The patient is young and in good health and should have responded very well to his therapy. I agree with the peer reviewer who determined that 12 post-op therapy visits would be reasonable for this patient's diagnosis. After this, a home based strength and conditioning program would have been reasonable, and a satisfactory protocol for returning the patient to work.
The documentation provided for this review does not yield any clinical evidence that the therapy provided on the disputed dates of service was beneficial to the patient. On 8/9/02 the patient pain scale was still 5/10 some five months after surgery. It is possible that some of the treatment protocol was causing an iatrogenic nocebo effect from over utilization or the continuation of inappropriate treatment. Numerous daily treatment notes state that inflammation was present, yet the patient was doing squats, leg presses, hamstring curls

and treadmill exercises. Sharp, burning pain was consistently noted, yet the exercises continued. The documentation has failed to establish how the disputed services were necessary.

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,