MDR Tracking Number: M5-03-0544-01

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 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 office visits, required reports, data analysis and physical therapy were found to be not medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 31st day of January 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

January 8, 2003

Re: IRO Case # M5-03-0544

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 she fell and sustained injuries to her cervical and lumbar spine. She received chiropractic treatment, and was also seen by an orthopedist and a neurologist for evaluation. An MRI, a CAT scan and an EMG/NCS were performed.

Requested Service
Chiropractic treatment 10/12/01 through 5/30/02

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

Rationale
The documentation submitted has failed to substantiate the necessity or efficacy of chiropractic treatment. There is little, if any, documented clinical subjective or objective evidence that the patient has benefited from chiropractic treatment. Treatment rendered should result in substantive, continued measures of improvement over time, and the documentation in this case has failed to show, even months post injury, that treatment has been effective. The documentation submitted showed that the patient had received various forms of therapy including ultrasound, hot/cold packs, joint mobilization, therapeutic exercises, electrical muscle stimulation, traction, massage, neuromuscular reeducation and myofascial release, all with little, if any documentation substantiating its necessity or its benefits to the patient. The patient actually stated after extensive treatment that she was not getting any better, and at times felt that she was getting worse with treatment.

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,