THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: SOAH DOCKET NO. 453-03-4445.M5

MDR Tracking Number: M5-03-1373-01

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/services, including office visits and therapies 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 the chiropractic treatment/service 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 9/9/02 to 10/14/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 16th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

July 15, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1373-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. 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 chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor 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, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. The patient reported that while at work he sustained an injury to his abdomen. The patient was evaluated and treated with chiropractic care and physical therapy. The patient underwent a surgical evaluation where it was determined that the patient had bilateral inguinal hernia. The patient underwent repair on 7/22/02. The patient was then treated with post surgical physical therapy from 8/9/02 through 9/27/02. The patient has also been treated with chiropractic care that included ultrasound, myofascial release and exercises.

Requested Services

Chiropractic treatments from 9/9/02 through 10/14/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his abdomen on ___. The ___ chiropractor reviewer also noted that the patient was evaluated and treated with chiropractic care and physical therapy. The ___ chiropractor reviewer further noted that the patient was found to have bilateral inguinal hernias and underwent hernia repair on 7/22/02. The ___ chiropractor reviewer indicated that the patient was treated post surgically with physical therapy and chiropractic care that included ultrasound, myofascial release and exercises. The ___ chiropractor reviewer explained that the documentation provided does not support the medical necessity for the treatment rendered from 9/9/02 through 10/14/02. Therefore, the ___ chiropractor consultant concluded that the chiropractic treatments from 9/9/02 through 10/14/02 were not medically necessary to treat this patient's condition at this time.

Sincerely,

___