MDR Tracking Number: M5-03-1445-01

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 treatments 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 1/21/02 to 8/6/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 17th day of June 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: June 10, 2003

RE: MDR Tracking #: M5-03-1445-01
IRO Certificate #: 5242

____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating 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 the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

According to the documentation submitted, the alleged injury occurred on ___ when the claimant was struck on the left shoulder by a pipe and was forced into a lumbar extension posture. The claimant complained of left shoulder pain, low back pain, and left leg pain. He underwent 2 weeks of physical therapy followed by six weeks of chiropractic therapy under ___. Chiropractic therapy continued under ___ from 06/20/01 through 08/06/2002.

Requested Service(s)

The medical necessity of the chiropractic services rendered from 01/21/02 through 08/06/02.

Decision

I agree with the insurance carrier that the chiropractic treatments, including all applicable therapy and rehabilitation, rendered by Dr. ___ from 01/21/02 through 08/06/02 were not medically necessary.

Rationale/Basis for Decision

By the time the claimant presented to Dr. ___, he had already undergone eight weeks of physical and chiropractic therapy without any noted objective improvement. The only reasons that physical/chiropractic care would be indicated beyond the initial eight weeks of post-injury care are if some objective improvement has occurred in the claimant's condition and the claimant has not yet reached maximum medical improvement. Continued passive and active therapy from months 8 through 16 post-injury without any documented, objective improvement is simply not medically reasonable or necessary.