

**THIS DECISION HAS BEEN APPEALED. THE  
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:  
SOAH DOCKET NO. 453-03-3459.M5**

MDR Tracking Number: M5-03-1454-01

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 office visits with manipulations, reports, physical therapy sessions and DME 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 office visits with manipulations, reports, physical therapy sessions and DME 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 3/13/02 to 12/11/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 6<sup>th</sup> day of May 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

**IRO Certificate #4599**

**NOTICE OF INDEPENDENT REVIEW DECISION**

April 14, 2003

**Re: IRO Case # M5-03-1454-01**

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, Rule 133.308 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 IRO's, 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 for review, is as follows:

#### History

The patient injured her shoulder and lower back on \_\_\_\_. She had chiropractic care, injections, surgery and physical therapy.

#### Requested Service(s)

Office visits, manipulations, required reports, physical therapy sessions, DME 3/13/02-12/11/02

#### Decision

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

#### Rationale

Chiropractic treatment has been extensive since 1999. The documentation presented for this review fails to show any lasting relief of the patient's symptoms. If anything, her clinical condition has deteriorated. The documentation of chiropractic treatment does not show relief of the patient's symptoms. Although all previous treatments had failed, treatment was continued. Treatment must be reasonable and effective in relieving symptoms or improving function in order for treatment to be allowed to continue, and in this case it had failed. It did not relieve, cure or enhance the patient's ability to return to work. The documentation presented failed to show how treatment was beneficial to the patient.

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

Sincerely,