MDR Tracking Number: M5-03-1538-01

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 11/7/02 to 11/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 11th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

July 9, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-03-1538-01

___ 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 33 year-old female who sustained a work related injury on ___. The patient reported that while at work she was hit in the left shoulder by a pallet. The patient underwent an MRI of the cervical spine and left shoulder on 7/21/02. The patient has undergone electrodiagnostic studies on 7/19/00. The diagnoses for this patient include cervical HNP, rotator cuff syndrome, shoulder impingement and numbness and tingling. Treatment for this patient has included massage therapy, therapeutic exercises, spray and stretch therapy and electrical stimulation. The patient reported an exacerbation on 11/7/02.

Requested Services
Chiropractic treatments and services rendered from 11/7/02 through 11/22/02.

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 33 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient included cervical herniated nucleus pulpus, rotator cuff syndrome, shoulder impingement and numbness and tingling. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included massage therapy, therapeutic exercises, spray and stretch therapy and electrical stimulation. The ___ chiropractor reviewer indicated that the treatment for this patient's condition has been ongoing for over two years without any documentation of improvement in the patient's condition. The ___ chiropractor reviewer explained that there is no documentation on 11/7/02 describing an exacerbation in the patient's condition or how it occurred. The ___ chiropractor reviewer indicated that the documentation provided does not support an exacerbation since the treatment this patient has received does not appear to have ended at any time. The ___ chiropractor reviewer explained that the documentation provided does not show medical necessity as the patient has not made any real improvement. Therefore, the ___ chiropractor consultant concluded that the chiropractic treatments and services rendered from 11/7/02 through 11/22/02 were not medically necessary to treat this patient's condition.

Sincerely,