

MDR Tracking Number: M5-03-1631-01

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, 2003 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 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 was 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 was 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 4/2/02 through 7/8/02 are denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 9th day of May 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division
MQO/mqo

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

May 5, 2003

Re: IRO Case # M5-03-03-1631

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 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 physician who is Board Certified in Orthopedic Surgery. 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 is a 44-year-old male who on ___ sustained an injury to his cervical spine and left shoulder while lifting a 19 inch television onto a cart. The patient presented to the treating chiropractor on 9/11/01, and an extensive chiropractic and physical therapy treatment plan was started on both conditions for six weeks, three times per week. The patient slowly improved, however, therapeutic treatment persisted for almost ten months. In December, 2001, the patient was subjectively improving, but a home exercise program was not started. Instead, the patient continued to return for chiropractic treatment and modalities for the next seven months.

Requested Service

Chiropractic treatments 4/2/02-7/8/02

Decision

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

Rationale

Reasonable treatment plans for soft tissue injuries to the cervical spine and shoulder include 10-12 weeks of physical therapy, chiropractic treatments and modalities. Patients who do not respond to this treatment plan should be referred for orthopedic surgical evaluation, or a required medical evaluation. Persistent shoulder pain with MRI evidence of tendinosis in this patient's age group should not be treated with more therapy, but rather, a subacromial steroid injection or surgical decompression. In addition, prolonged physical therapy has not been shown to improve chronic mechanical neck pain with no objective evidence of stenosis or arthrsis. Therefore, the treatment provided to this patient from 4/22-7/18/02 was not indicated. The patient should have been placed at MMI, referred for a required medical examination, or referred for an orthopedic surgery evaluation.

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

Sincerely,