

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-03-4461.M5

MDR: Tracking Number M5-03-1686-01

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 the 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 4/11/02 to 9/17/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 15th day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

July 3, 2003

Re: IRO Case # M5-03-1686-01

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 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 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, is as follows:

History

The patient injured her neck and back on ___ when she slipped and fell. She began chiropractic treatment on 3/26/02. She has had two MRIs, physical therapy, chiropractic manipulation, therapeutic exercises, and epidural steroid and facet injections.

Requested Service(s)

Chiropractic treatments 4/11/02 to 9/17/02

Decision

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

Rationale

The patient condition never improved, but instead her condition deteriorated during treatment. During an examination on 6/13/02 the patient stated that she had had no improvement for one month and that treatment had aggravated her condition. During the 6/13/02 examination the patient complained of severe neck, lower back, shoulder and arm pain every day, yet she had no positive orthopedic tests, no palpable tenderness, normal cervical spine and lumbar spine range of motion, normal muscle strength, normal DTRs, no palpable muscle spasm and normal sensation to touch and pin prick. It is possible that there was symptom magnification, as subjective complaints were not supported by objective findings.

In the notes of the treating chiropractor's examination on 6/14/02, (one day after the 6/13/02 examination with a different chiropractor), it is stated that the patient had

palpable muscle spasms and tenderness and improper movement of the cervical spine and lumbar spine. The 6/14/02 documentation is very limited, but there is a significant discrepancy in examination findings between the two doctors on successive dates. The treating doctor's documentation, however, had been the same, unchanged since the start of treatment some months earlier, making them somewhat questionable. Also questionable is the reliability of the patient's subjective complaints.

In my opinion, based on the documentation presented, treatment of the patient was excessive, inappropriate and iatrogenic. It was not provided in the least intensive setting and lacked objectively measured functional gains. The documentation failed to show how the disputed services were necessary.

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

Sincerely,