

MDR Tracking Number: M5-03-1921-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The Medical Review Division has reviewed the IRO decision and determined, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The chiropractic treatments from 9/3/02 through 10/4/02 were found to be medically necessary. The chiropractic treatment/services rendered from 10/9/02 through 11/5/02 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these chiropractic treatment charges.

This Finding and Decision is hereby issued this 17<sup>th</sup> of June 2003.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 9/3/02 through 11/5/02 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 17<sup>th</sup> day of June 2003.

David R. Martinez, Manager  
Medical Dispute Resolution  
Medical Review Division

DRM/cl

June 11, 2003

## NOTICE OF INDEPENDENT REVIEW DECISION

**RE: MDR Tracking #: M5-03-1921-01**

\_\_\_ 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 26 year-old female who sustained a work related injury on \_\_\_. The patient reported that while at work she slipped and fell on a wet floor. The initial diagnoses for this patient included unspecified backache, pelvic region segmental dysfunction, traumatic arthropathy of the shoulder and sacroiliac ligament strain. The patient underwent an MRI on 8/15/02. The patient has undergone NCV/EMG. The treatment for this patient has included lumbar facet block with sacroiliac injections, oral pain medications and chiropractic manipulations.

### Requested Services

Chiropractic treatments rendered from 09/03/02 through 11/05/02.

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

### Rationale/Basis for Decision

The \_\_\_ physician reviewer noted that this case concerns a 26 year-old female who sustained a work related injury to her low back and shoulder on \_\_\_. The \_\_\_ chiropractor reviewer also noted that the patient sustained a two region injury. The \_\_\_ chiropractor reviewer indicated that the patient's shoulder was progressing steadily and was resolved on 10/4/02. The \_\_\_ chiropractor reviewer noted that the low back never improved after extensive care. The \_\_\_ chiropractor reviewer also noted that the patient underwent epidural steroid injections that did not improve this patient's low back pain. The \_\_\_ chiropractor reviewer explained that because the patient sustained trauma in two regions, this alone could prolong recovery. The \_\_\_ physician reviewer indicated that 2-3 months of care is appropriate. However, the \_\_\_ chiropractor reviewer explained that a significant trial of conservative care without relief and not returning to work, would indicate that care is no longer medically necessary. Therefore, the \_\_\_ chiropractor consultant concluded that the chiropractic treatments rendered from 09/03/02 through 10/04/02 were medically necessary to treat this patient's condition. However, the \_\_\_ physician consultant also concluded that the chiropractic treatments rendered from 10/09/02 through 11/05/02 were not medically necessary to treat this patient's condition.

Sincerely,