

MDR Tracking Number: M5-03-2026-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General 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 dispute was received on 4-16-03.

The Medical Review 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 neuromuscular stimulator, special reports, office visits, physician education services, team conference, manual traction, and physical performance test 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 Medical Review Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service from 4-16-02 to 9-18-02 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 21st day of May 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION amended 5/20/04

July 3, 2003

Re: IRO Case # M5-03-2026-01

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 his neck, back, both shoulders and wrists on ___ when he was jacking up a container. He first presented to the treating chiropractor for treatment on 4/16/02.

Requested Service(s)

Application of neuromuscular stimulator, special reports, office visits, physician education services, team conference, manual traction, physical performance test 4/16/02 - 9/18/02

Decision

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

Rationale

The patient began treatment with the treating chiropractor almost a year and a half after his injury. He rated his pain at 3/10 on his initial visit. During the next five weeks of treatment his pain gradually increased to an 8/10 reported on 5/23/02, indicating that treatment was inappropriate and iatrogenic. The use of a neurostimulator three times a week was ineffective in relieving symptoms or improving function, and the documentation provided for this review fails to support its necessity.

An MRI showed a free fragment at C4-5. The prognosis for successful chiropractic treatment with this presentation is poor, and treatment never should have been initiated. One physician noted on 3/14/02 that the patient was a possible surgical candidate, but

recommended starting with a cervical facet block. In my opinion, chiropractic manipulation was contraindicated. The chiropractor, however, continued treatment even though the patient's condition was deteriorating.

The patient was reported to be at MMI on 4/3/01, and it was noted that any further treatment should be by an orthopedic surgeon and that no further treatment of the shoulders was necessary. Yet, over one year later, chiropractic treatment was initiated on the patient's neck, back, and shoulders. After an MMI date is reached all further treatment must be reasonable and effective in relieving symptoms or improving function, and the documentation presented for this review 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,
