

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 cervical manipulations were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that the cervical manipulation 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 3-7-01 through 1-2-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 25th day of July 2002.

Dee Z. Torres, Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and subsequently re-delegated by Virginia May, Deputy Executive Director.

August 2, 2002

Texas Workers' Compensation Commission
Attention: Rosalinda Lopez, Case Manager
Medical Dispute Resolution
4000 South IH-35, MS 48
Austin, TX 78704-7491

REVISED LETTER

Re: Medical Dispute Resolution
MDR #: M5-02-2117-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

This letter is to correct a review dated July 8, 2002 in which we are revising the wording of *i.e.* 1st and 2nd paragraphs of "C. OPINION". This

is now corrected in the Medical Case Review. This revised letter **IN NO WAY** changes the opinion of the reviewer.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a Chiropractic Doctor.

THE REVIEWER OF THIS CASE **AGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted.

Sincerely,

MEDICAL CASE REVIEW

This is for ___. I have reviewed the medical information forwarded to me concerning Case File #M5-02-2117-01, in the area of Chiropractic. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request, with denials of dates of services ranging from 3/07/01 to 1/02/02.
2. EOB's denying payment ranging from 3/01 to 12/01.
3. Order for Designated Doctor Exam by ___.
4. ___, letter of correspondence, 6/04/01.
5. Peer review report dated 3/16/01.
6. Impairment rating report by ___ with MMI on 9/18/01 and 7% impairment.
7. Impairment rating report, RME, by ___, Orthopedics, with MMI on 3/26/01 and 0% impairment.
8. Designated Doctor Exam for low back injury, dated 12/06/99, with MMI on 10/31/00 and 11% impairment.
9. Physical therapy review on 4/10/02.
10. Peer review report on 3/06/02.
11. Exam information by ___, dating from 12/21/00 to 3/22/01.
12. MRI of the lumbar spine, dated 1/30/01.

B. SUMMARY OF EVENTS:

The patient injured his low back on ___ in a work-related accident. He had a previous low back injury on ___, for which he was MMI'd on 10/31/00 with 11% impairment by a designated doctor. The patient presented to ___, a chiropractor, office on 12/04/00. Treatment ensued. Cervical manipulation was given and billed for throughout the course of treatment. The patient was also treated by ___ during this course. An MRI of the lumbar spine was taken on 1/30/01. The patient was MMI'd on 3/26/01 with 0% impairment for the 12/04/00 injury by ___, Orthopedics, RME. The patient was then impaired by ___, treating doctor, on 9/18/01 with 7% impairment and MMI established.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

___, the treating doctor, has not submitted documentation (case history, mechanism of injury, exam findings, treatment plan, rationale) to support treatment of the cervical spine or to warrant medical-necessitated cervical spine manipulation.

All medical information provided is relevant to the lumbar spine injury. No diagnosis or condition of the cervical spine has been identified.

The sources of screening criteria are 17 years of clinical experience and spinal treatment guidelines.

In summary, ___, the treating doctor, has not demonstrated injury, diagnosis or rationale for cervical spine manipulation.

D. ADDITIONAL COMMENTS:

None.

E. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 1 August 2002