

MDR Tracking Number: M5-02-2318-01

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 office visits with manipulations were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that office visits with manipulations 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 4-9-01 through 10-10-01 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of August 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.

Enclosure: IRO Decision

IRO Certificate #4599

Amended NOTICE OF INDEPENDENT REVIEW DECISION

August 10, 2002

Re: IRO Case # M5-02-2318-01

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 IRO's, 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 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 ___ reviewer who reviewed this case has determined that, based on the medical records provided, the requested treatment was not medically necessary. Therefore, ___ agrees with the adverse determination regarding this case. The reviewer's decision and the specific reasons for it, is as follows:

This case involves a 45-year old female patient injured on ____. Approval was requested for chiropractic office visits 4-9-01 through 10-10-01. I agree with the carrier's decision to deny the requested chiropractic treatment. Subjectively, the patient did not respond to the treatment given at any time after her injury. Objectively, the relatedness of the treatment to the patient's injury was not established. The patient's response to conservative treatment appears to have failed, and the patient's symptoms even worsened during treatment. There are no reports given as to why treatment for the disputed dates was even restarted. There are no objective findings such as deep tendon reflexes, specific cervical and lumbar range of motion, or orthopedic/neurologic tests to support continued treatment for the dates in dispute. Subjective complaints by the patient consistently show that she is very stressed all the time, and this probably has to be addressed medically.

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

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing. A request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3). This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P O Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

Sincerely,