

MDR Tracking Number: M5-02-2337-01

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 that **the requestor did not prevail** on the issues of medical necessity. Therefore, in accordance with §133.308(q)(9), the Commission **Declines to Order** the respondent to refund the requestor for the paid IRO fee.

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 therapeutic exercises, myofascial release and joint mobilization were found to not be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 8th day of January 2003.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 19, 2002

Re: IRO Case # M5-02-2337-01

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, Rule133.308 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 and who also is a Certified Strength and Conditioning Specialist. 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:

History

This case involves a 39-year-old male who on ___ suffered a laceration to his left hand while tightening a pump with a wrench. He was lacerated and sutured. On 7/10/01 he was diagnosed with a hand laceration and deep and superficial muscle spasms. He was to be seen by his treating chiropractor five times a week for two weeks and three times a week thereafter. He received therapeutic exercises, myofascial release and joint mobilization

Requested Service(s)

Chiropractic care 7/10/01 through 7/27/01

Decision

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

Rationale

Chiropractic management in the form of therapeutic exercises, myofascial release and joint mobilization appears neither reasonable nor necessary for this type of injury. Notes from the medical center state that there was no vascular compromise, only mild pain, sensation was intact and range of motion was normal. The patient was told by the medical center to return to work the next day, but not to lift, push or pull any objects until the sutures were removed. There was no mention of any need for further rehabilitation by the physicians or the RN who treated the patient at the medical center.

The treating chiropractor's notes do not justify any form of therapy or joint mobilization. The reasoning behind joint mobilization is unsupported by research, and it would be unreasonable to assume that they could positively promote the healing process. Just a few stretching and strengthening exercises would have been sufficient rehabilitative support for this injury.

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,