

MDR Tracking Number: M5-02-2493-01

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 the work hardening and traction were not medically necessary.

Also in dispute were office visits and muscle testing that were denied based upon the medical fee guideline. The requestor has since notified the Commission that they will withdraw these additional disputed services.

Based on review of the disputed issues within the request, the Division has determined that work hardening and traction fees were the only fees involved in the medical dispute denied on the basis of lack of medical necessity. As the treatment was not found to be medically necessary and the requestor has withdrawn all further medical fee guideline disputes, reimbursement for dates of service from 6/20/01 to 2/12/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 22nd day of October 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

September 13, 2002

Re: IRO Case # M5-02-2493

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, who is licensed by the State of Texas, and who is also 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

The patient reportedly slipped in some water and sustained a fracture of the distal radius on _____. An orthopedic surgeon placed him in a long arm cast. On 6/19/01 he was seen by a chiropractor and taken off work.

Requested Service(s)

Chiropractic care 6/20/01 – 2/12/02, including codes 97122, 97545 WH, 97546WH and 97750 FC

Decision

I agree with the carrier's decision to deny the requested services 6/20/01 through 2/12/02.

Rationale

Chiropractic care was not medically necessary for the diagnosis given. Documentation was insufficient and unresponsive for any chiropractic care. The patient was never totally disabled. He was able to return to work with a cast. Based on the documentation presented as of 10/23/01,

the patient was classified at medium work and borderline heavy work. At that point he started a work hardening program. The documentation does not support a work hardening program because of the patient's classification. The patient could have progressed equally as well with a home-based program of therapeutic exercises and a regimented strength and conditioning program.

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,
