

MDR Tracking Number: M5-02-2506-01

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 respondent prevailed** on the issues of medical necessity. Therefore in accordance with §133.308(q)(9), the Commission hereby **Declines to Order the respondent** to reimburse the **requestor** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 disputed services were found to **not** be medically necessary. The respondent raised no other reasons for denying reimbursement for these services.

This Decision is applicable to date of service is 7/30/01.

This Decision is hereby issued this 1st day of November 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 28, 2002

Re: IRO Case # M5-02-2506

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 physician who is Board Certified in Surgery. 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 slipped while wiping tables, striking her left side to a counter. She was seen by a chiropractor with numerous complaints including neck, back, jaw, left rib, left abdominal, left knee, left ankle pain and headache. Over one month after the fall, a CT of the abdomen was done.

Requested Service(s)

CT scan of the abdomen

Decision

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

Rationale

The patient was seen in the ER after the fall. No CTscan was done and no surgery consult was mentioned. The mechanism of the fall is low injury, and the likelihood of solid organ injury was quite low. Had the patient had appropriate signs, it would have been appropriate to consider a CT scan in the initial post-injury time frame; a CT ordered one month after the fall would provide little information. It was actually performed 6 ½ weeks after the injury. Any serious intra abdominal injury would have declared itself by then.

A CT scan was not indicated. If there was concern about a serious intra abdominal injury, an immediate consultation with an appropriate specialist should have been requested, instead of waiting weeks for an outpatient CT.

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,