

MDR Tracking Number: M5-02-2685-01

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 chiropractic treatment (including office visits, aquatic therapy/exercises, massage therapy and one to one therapy) rendered were not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that chiropractic treatment (including office visits, aquatic therapy/exercises, massage therapy and one to one therapy) fees were the only fees involved in the medical dispute to be resolved. As the treatment, (chiropractic treatment - including office visits, aquatic therapy/exercises, massage therapy and one to one therapy) was not found to be medically necessary, reimbursement for dates of service from 6/14/01 through 1/28/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 28th day of October 2002.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

October 18, 2002

Re: IRO Case # M5-02-2685

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 was reportedly injured in ___ when she slipped and fell on her right shoulder. After medication and physical therapy did not help, the patient was given chiropractic treatments, which also did not help. Surgery was performed on 4/11/02 with poor results. The patient received extensive therapy after the surgery with poor results. A second surgery was performed with better results. The patient was evaluated as having reached MMI on 3/22/02.

Requested Service(s)

Chiropractic treatment 6/14/01-1/28/02

Decision

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

Rationale

The documentation provided fails to support the need for the volume of one to one therapy rendered. The documentation fails to give reasons why rehabilitation could not be done in a group setting or at home. No reason was ever given as to why the patient had to have one to one therapy to the extent that it was given.

That this patient was unable to perform exercises without one to one supervision does not seem realistic when considering the documentation. Within one month of the first surgery, the chiropractor's notes state that the patient's range of motion had increased substantially, yet one to one therapy continued still with no reason why the patient had to have it, or why group therapy or home based exercises would not help the patient to the same extent as one to one supervision.

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,