

MDR Tracking Number: M5-02-2702-01

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 care, including office visits and therapies, rendered was not medically necessary.

Based on review of the disputed issues within the request, the Division has determined that Chiropractic care, including office visits and therapies fees were the only fees involved in the medical dispute to be resolved. As the treatment, Chiropractic care, including office visits and therapies was not found to be medically necessary, reimbursement for dates of service from 2/16/02 through 4/10/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of October 2002.

Carol R. Lawrence  
Medical Dispute Resolution Officer  
Medical Review Division

CRL/crl

**IRO Certificate #4599**

### **NOTICE OF INDEPENDENT REVIEW DECISION**

September 13, 2002

**Re: IRO Case # M5-02-2702-01**

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, 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 was injured on \_\_\_ when he was backing his bulldozer down a hill, when the vehicle suddenly stopped, jarring his neck. He has undergone extensive conservative treatment, rehabilitation, work hardening and injections.

#### Requested Service(s)

Chiropractic care 2/16/02 through 4/10/02

#### Decision

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

#### Rationale

The therapeutic rehabilitation documentation presented shows no improvement, and in fact the patient's symptoms intensified considerably over the treatment period. Documentation of subjective complaints indicate moderate cervical pain with each visit. On 3/6/02 it is noted that the pain is now radiating into the right arm, yet the exercise program was continued and even intensified. On 3/15/02 it is documented that the pain is now severe on the left side of his neck. All symptoms prior were right-sided in nature, yet the exercise program was continued. Documentation on 3/15/02 states that even with severe neck pain, the patient completed the therapeutic exercises "with no complaints." If the patient was in severe pain, then exercises should not have been continued, and they would have been impossible to perform. The validity of the patient's complaints and treatment regimen is questionable throughout the dates in dispute. Physical therapy, supervised therapeutic exercises and work hardening provided no restorative benefit to the patient. There was no functional gain in range of motion, strength or pain reduction.

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,

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