

MDR Tracking Number: M5-02-2958-01

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 **or January 1, 2003** 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. Dates of service 1-11-02 through 1-25-02 are over one year old and not eligible for review. The IRO agrees with the previous determination that the physical therapy sessions were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that the medical necessity fees were the only fees involved in the medical dispute to be resolved. As the treatment was not found to be medically necessary, reimbursement for dates of service from 1-27-02 through 7-19-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of May 2003.

Dee Z. Torres  
Medical Dispute Resolution Officer  
Medical Review Division

DZT/dzt

**IRO Certificate #4599**

**Amended per Instruction of TWCC MDR Officer, Noel Beavers 6/12/03**  
**NOTICE OF INDEPENDENT REVIEW DECISION**

June 13, 2003

**Re: IRO Case # M5-02-2958**

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. 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 is a 33-year-old diabetic male reportedly injured at work on \_\_\_. He was using a carpet cutter when he lacerated his left thumb. The patient initially was seen by a DO who diagnosed the patient with a superficial wound of the thumb, and who closed and dressed the wound. The DO prescribed an antibiotic. The patient was released back to work, but did not return to work because he believed that the medication had mixed up his sugar levels. The DO released the patient to his primary MD and diabetic care facility. The patient sought chiropractic care for his injury on \_\_\_. The chiropractor released the patient from work and administered therapeutic procedures.

#### Requested Service(s)

Office visits, special report, radiological exam, therapeutic procedures 7/31/01 – 9/17/01

#### Decision

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

#### Rationale

Treatment of lacerations and diabetes are not conditions covered under the guidelines set forth by the Texas Board of Chiropractic Examiners. The disputed treatment was unnecessary, as the wound was superficial and should therefore not have required any rehabilitative treatment.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

Sincerely,

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