

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 **Declines to Order** the respondent to refund the requestor for the paid IRO fee.

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 office visits with manipulation and office visits were found to be not be medically necessary. The respondent raised no other reasons for denying reimbursement.

This Order is hereby issued this 6th day of December 2002.

Noel L. Beavers
Medical Dispute Resolution Officer
Medical Review Division

NLB/nlb

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

November 12, 2002

Re: IRO Case # M5-02-3009

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 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 injured in ___ while unloading boxes weighing 35 to 80 lbs from a truck. The next day he felt neck and low back pain. He initiated chiropractic treatment, and on 6/11/01 was referred for a neurological consult.

Requested Service(s)

Chiropractic care 12/24/01 – 3/25/02

Decision

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

Rationale

The documentation presented for treatment prior to the dates in dispute shows no progress, indicating that further chiropractic treatments would most likely not be of any benefit, and therefore would be unnecessary. The patient's sprain/strain injury was superimposed on preexisting degenerative changes of the spine and it should have responded with four to six weeks of treatment, which it did not. Further, documentation prior to the dates in dispute was unsupportive of continued treatment for a sprain/strain injury beyond the 4 to 6 week time frame.

Treatment beyond this would have been for the preexisting degenerative symptoms. The documentation presented for the disputed services shows no clinical improvement and is very vague and limited as to objective clinical findings and subjective complaints, and therefore is unsupportive of any continuing chiropractic care.

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,