

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 requestor withdrew all disputed services denied on the basis of the *Medical Fee Guideline*.

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 physical therapy and office visits 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 physical therapy and office visit 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 9/5/01 to 5/31/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of January 2003.

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 # M5-02-3140

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 injured his left shoulder in _____. He has had two shoulder surgeries and therapy.

Requested Service(s)

Chiropractic care 9/5/01 – 5/31/02

Decision

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

Rationale

The documentation submitted fails to show the need for the services in dispute. Two surgeries have failed, and it is beyond the scope of conservative care to help the patient. The documentation presented states that the shoulder pain was exacerbated after the second surgery, possibly due to another tear in the rotator cuff or labrum, and further surgery may be necessary. No form of chiropractic care would be beneficial in this case. The documentation for dates prior to the dates in dispute shows that conservative treatment would not be beneficial, and therefore would be unnecessary.

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,