MDR Tracking Number: M5-03-0392-01

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, 2003 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 requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

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 once a month were **found to be medically necessary**. The respondent raised no other reasons for denying reimbursement for these charges.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 10/3/01 through 3/29/02.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 17th day of June 2003.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

Date: December 11, 2002

Rosalinda Lopez
TWCC
4000 South IH-35, MS -48
Austin, Texas 78704-7491

RE: MDR Tracking #: M5-03-0392-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer. The Chiropractic physician reviewer has signed a certification statement stating 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 the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The records provided for review are very voluminous. It appears the claimant suffered low back injury while trying to grab on to a falling 400-500 pound barrel back on ___. The claimant had a disc herniation at the L5/S1 level as evidenced on MRI. He received a lumbar epidural steroid injection on 8/2/00 and finally ended up having L5/S1 surgery on 11/16/00. The claimant initially saw a chiropractor on 2/23/01 and stated he had no post operative care to date. It appears chiropractic care has been ongoing from 2/23/01 onward. Multiple peer reviews and independent medical examinations are reviewed revealing the claimant has essentially reached maximum therapeutic benefit through chiropractic care. The overall documentation from multiple peer reviewers states the claimant has not improved via the chiropractic care and therefore chiropractic care was no longer indicated and has not been indicated for quite some time. The claimant saw the doctor on 3/5/01 and he felt the claimant needed a discogram and that he may need the IDET procedure. The claimant saw another doctor on 10/22/01 and, according to the records, the clinical examination at this time was very good and the doctor felt the IDET procedure would not be needed. The treating chiropractor, referred the claimant over to another doctor on 10/25/01. At this point it was reported the claimant had sustained no relief from surgery. It was also indicated the claimant was a 1.5 pack per day smoker. The claimant had positive root tension signs and evidence of radiculopathy on the right in the lower extremity. The doctor requested a repeat CT/myelogram of the lumbar spine be done. The chiropractor saw the claimant for designated doctor evaluation on 12/14/01 and felt the claimant was not at maximum medical improvement mainly because the results of the CT/myelogram which was done only 3 days prior to this date were not known. The doctor performed a peer review in April of 2002 and he felt the claimant's current signs and symptoms were related to the injury; however, further chiropractic care would not be reasonable or medically necessary. It should also be noted the

chiropractor felt further chiropractic treatment and physical therapy were not indicated. The chiropractor also felt the claimant would not need further chiropractic treatment as of his review of 10/26/01. The doctor in his review of April of 2002, left open the possibility for repeat surgery; however, he also did not have the most recent CT/myelogram study for review which was done on 12/11/01. He did not, however, feel the IDET procedure would be needed. The overall documentation reveals the claimant has not sustained any appreciable improvement via chiropractic care. Multiple pre-authorization notes are reviewed. A repeat surgery appeared to be denied via the pre-authorization process mainly due to the conflicting evidence in the documentation regarding several different interpretations of the 12/11/01 CT/myelogram study. It appears the doctor felt there was a fairly significant and large herniation at the L5/S1 level which was causing right sided S1 nerve root impingement and he further felt the claimant demonstrated clinical evidence of this. Meanwhile, the radiologist who read the initial films of 12/11/01 felt the CT/myelogram was normal. It appears the claimant did have a designated doctor evaluation scheduled with the doctor on 12/2/02. I do not have his report available in the documentation for review. Multiple psychotherapy and biofeedback notes are reviewed. A repeat MRI of the lumbar spine of 1/2/01 is reviewed. The discogram report of 4/12/01 is reviewed which reveals the claimant did have some left calf pain when the L1/2 disc was injected and pressurized. The claimant also had a reported L5/S1 torn disc anulus which was not producing concordant pain. It appears a chronic pain management program has been recently denied through the pre-authorization process. By my review of the documentation, the claimant was seen 7 times in October 2001, 9 times for chiropractic care in November of 2001, 3 times in December 2001, 14 times in January 2002, 5 times in February 2002, and 3 times in March of 2002.

Requested Service(s)

Please review and address the medical necessity of the outpatient services rendered from 10/3/01 through 3/29/02. This would obviously be in reference to the chiropractic office visits which were rendered during this time which have number anywhere from 40-42 visits.

Decision

I agree with the insurance carrier that most of the chiropractic services rendered from 10/3/01 through 3/29/02 were not reasonable and medically necessary. I disagree with the insurance carrier; however, that completely all of the office visits rendered from 10/3/01 through 3/29/02 were not reasonable and medically necessary.

Rationale/Basis for Decision

Even though it was clear the claimant had more than enough chiropractic treatment and had not progressed via the chiropractic care, it is also clear the treating physician of record still has a responsibility to the claimant in the sense that the treating physician still needs to see the claimant periodically to maintain referrals and to make appropriate clinical decisions. The claimant's course of treatment still needed to be directed and coordinated to some degree during the October of 2001 through March of 2002 time period. A discrepancy occurred between what 2

different medical doctors felt were the results of the 12/11/01 CT/myelogram study. In the designated doctor evaluation report of 12/14/01, the doctor felt the claimant was not at maximum medical improvement due to the lack of the availability of the CT/myelogram report. After all the CT/myelogram had only been done 3 days prior to the 12/14/01 designated doctor visit. It appears this discrepancy among physicians, chiefly between the doctor and the radiologist who read the 12/11/01 CT/myelogram, has not been resolved. The doctor felt the herniated disc at L5/S1 was fairly significant and did encroach upon the right S1 nerve root. He further felt the claimant had evidence to support the findings of the CT/myelogram. The radiologist who read the CT/myelogram of 12/11/01 felt the study was completely normal. I do feel it is certainly reasonable for the treating doctor to see the claimant at least once per month during the October of 2001 through March of 2002 time frame. It is obvious there are still issues that need to be addressed and, in my opinion, it is perfectly reasonable and medically necessary that the treating physician see the claimant once per month until some of these issues are resolved. It is my opinion that even though treatment was non-effective and no longer reasonable or necessary for quite some time, office visits every 30 days or once per month would be appropriate in order to help continue to direct and maintain this claimant's overall course of treatment and referrals. The treating doctor, after all, has more than a treating physician role with respect to actual treatment rendered. He also must coordinate and maintain the claimant until maximum medical improvement issues have been resolved. It is therefore my opinion that office visits every 30 days or once per month from 10/3/01 through 3/29/02 would be appropriate, reasonable and medically necessary. Any kind of physical therapy or chiropractic manipulation rendered during that time would not be considered appropriate in that the claimant has obviously had voluminous amounts of chiropractic treatment to date.

This decision by the IRO is deemed to be a TWCC decision and order.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of June 2004.