MDR Tracking Number: M5-03-0994-01

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 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, the total amount recommended for reimbursement does not represent a majority of the medical fees of the disputed healthcare and therefore, the **requestor did not prevail** in the IRO decision. Consequently, the requestor is not owed a refund of the paid 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 were found to be medically necessary. All other treatment/services rendered (electrical stimulation, manual traction, myofascial release, massage and reports) were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these office visit 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 6/28/02 through 9/6/02 in this dispute.

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 23rd day of July 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

CRL/cl

NOTICE OF INDEPENDENT REVIEW DECISION

March 20, 2003

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
4000 South IH-35, MS 48
Austin, TX 78704-7491

RE:

MDR Tracking #: M5-03-0994-01
IRO Certificate #: 4326

___ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional 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

This 49 year old male sustained a work-related injury on ___ when he was carrying a piece of heavy iron and stepped in an electrical hole in the ground. The patient was referred to for an evaluation on 07/15/02. MRIs of the lumbar and cervical spine were performed on 07/23/02. The MRI of the cervical spine revealed the presence of a central disc herniation at C3-4 with obliteration of the subarachnoid space and compression of the spinal cord, a central disc herniation at C4-5, C5-6, and C6-7 with obliteration of the subarachnoid space and compression of the spinal cord, and disc herniation at C6-7 and bilateral C7 nerve root compression, central spinal stenosis from C3-4 through C6-7, and bilateral foraminal stenosis at C4-5 and C5-6. The lumbar MRI study revealed a diffuse disc bulge with subtle foraminal disc protrusion at L3-4; a broad based disc protrusion at L4-5 and a probable disc protrusion at L5-S1.

Bilateral lateral recess stenosis was noted at L3-4 and L4-5. The patient was under the care of a chiropractor and from 06/28/02 through 09/06/02 underwent physical therapy in the form of electrical stimulation, manual traction therapy, myofascial release/soft, and massage, as well as special reports as insurance, and office outpatient visits.

Requested Service(s)

Physical therapy in the form of electrical stimulation, manual traction therapy, myofascial release/soft, and massage, as well as special reports as insurance, and office outpatient visits provided from 06/28/02 through 09/06/02.

Decision

It is determined that the office outpatient office visits provided from 07/26/02 through 09/06/02 were medically necessary to treat this patient’s condition.

However, the physical therapy in the form of electrical stimulation, manual traction therapy, myofascial release/soft, and massage provided from 07/26/02 through 09/06/02 as well as the special reports as insurance provided on 06/28/02 and 07/08/02 were not medically necessary to treat this patient's condition.

Rationale/Basis for Decision

The chiropractor treated the patient from 07/26/02 through 09/06/02 with treatment consisting of manipulation, myofascial release, manual traction, unattended electrical stimulation, and massage. The patient was referred to active physical therapy on 07/15/02 and began a course of active care with the physical therapist.

The physical therapy services (myofascial release, manual traction, message and unattended electrical stimulation) rendered from 07/26/02 through 09/06/02 were not medically necessary to treat this patient's condition. The patient had been treated on 16 occasions in the 6-week period prior to the dates of service in question and the medical records did not provide documentation that treatments were of benefit. The sustained use of passive physical therapy after the first month of care was not medically necessary. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain. For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. "Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain, Physical Therapy, 2001; 81:1641-1674.

The Philadelphia Panel indicated that for neck pain, therapeutic exercises were the only intervention with clinically important benefit, There was good agreement with this recommendation from practitioners (93%). For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. "Philadelphia Panel Evidence-based Guidelines on Selected Rehabilitation Intervention for Neck Pain", Physical Therapy, 2001; 81:1701-1717.

The Agency for Health Care Policy and Research: Clinical Practice Guideline Number 14, "Acute Low back Problems In Adults" indicates that "the use of physical agents and modalities in the treatment of acute low back problems is of insufficiently proven benefit to justify its cost. They did note that some patients with acute low back problems appear to have temporary symptomatic relief with physical agents and modalities. Therefore, the use of passive physical therapy modalities (hot/cold packs, electrical stimulation) is not indicated after the first 2-3 weeks of care.

The Royal College of General Practitioners indicates that, although commonly used for symtpomatic relief, the passive modalities (ice, heat, short wave diathermy, massage, and ultrasound) do not appear to have any effect n clinical outcomes. Royal College of General Practitioners, "Clinical Guidelines for the Management of Acute Low Back Pain, Review Date: December 2001.

As the patient was enrolled in an active physical therapy program as of 07/15/02, the continued use of passive care was not medically necessary to treat the patient's condition. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result. Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice parameters, Gaithersburg, Maryland, 1993.

While the office visits rendered from 07/26/02 through 09/06/02 were medically necessary for the treatment of the patient's condition, no information was found in the medical record documentation regarding the special reports that were done on 06/28/02 and 07/08/02.

Therefore, it is determined that the office outpatient office visits provided from 07/26/02 through 09/06/02 were medically necessary to treat this patient's condition. However, the physical therapy in the form of electrical stimulation, manual traction therapy, myofascial release/soft, and massage provided from 07/26/02 through 09/06/02 as well as the special reports as insurance provided on 06/28/02 and 07/08/02 were not medically necessary to treat this patient's condition.

Sincerely,