MDR Tracking Number: M5-03-2198-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General 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. This dispute was received on 05-05-03.

The IRO reviewed electrical stimulation, medical team conference, office visits, application of surface neuro-stimulator, special reports, whirlpool therapy, joint mobilization, and manual traction rendered from 05-08-02 through 02-17-03 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for electrical stimulation, medical team conference, office visits, application of surface neuro-stimulator, special reports, whirlpool therapy, joint mobilization, and manual traction. Consequently, the requestor is not owed a refund of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 07-09-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice. Relevant information was not submitted by the requestor in accordance with Rule 133.309 (g)(3) to confirm delivery of service for the fee component 99362 on 07-08-02 and 99080-73 on 01-10-03 in this dispute. Therefore reimbursement is not recommended.

This Decision is hereby issued this 17th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

July 1, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2198-01

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians.

All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY

This lady sustained a trip and fall with resultant injuries to the ankle, hip, lumbar spine region, and wrist. The hip was treated surgically with an arthroscopy. The lumbar spine underwent discogram that was noted to be positive. Several physicians evaluated and there was an effort to pursue a surgical option. However, it is my understanding that the surgery was not undertaken. There were multiple chiropractic visits long after the date of injury. The progress notes from the period in question note twice a week visits and no real improvement or change in the condition.

REQUESTED SERVICE (S)

1. Electrical Stimulation
2. Medical Conference w/ team
3. Office visits
4. Application of surface neuro-stimulator
5. Special reports
6. Whirlpool therapy
7. Joint mobilization
8. Manual traction

DECISION

Uphold denial – endorse the determination made on pre-authorization.

RATIONALE/BASIS FOR DECISION

1. Electric Stimulation - - Passive modalities this long after the date of injury are not indicated, additionally the repetitive use of electrical myostimulation, and other passive modalities has been shown to contribute to the chronicity of the patient's subjective complaints while at the same time nurturing the development of physician dependence, illness behavior, and over-stimulation. (Guidelines for Chiropractic Quality Assurance and Practice Parameters, 1993.) The treatment plan has not been shown to be effective and should be considered excessive. It is surprising that the practitioner in this case would pursue such protracted palliative care when any lasting benefit is elusive. The Texas labor code states that continued care is reasonable if it cures or relieves the effects naturally resulting from the compensable injury but this would be limited in scope and duration and thus is derived the definition of maximum medical improvement. That standard has not been met. Lastly, this device is not within the prevailing

2. standard of care for rehabilitation professionals, must be considered to be experimental, and accordingly is not reasonable and necessary care for the injury sustained.
3. Medical conference w/ team – The "position statement" provider by the requestor indicates that the team conference was a discussion between the requestor and the adjuster. This fails to meet the definition of a team conference as per the MFG, page 28.
4. Office visits Weekly manipulations and palliative passive modalities cannot be continued indefinably and there has to be some reasonable time frame for treatment expectations to improve to a point of maximum medical improvement despite the subjective insistence of the claimant. Thus, with the treatment offered, and noting the timeframes involved, along with the treatment guidelines (Guidelines for Chiropractic Quality Assurance and Practice Parameters, 1993) adding to the chronicity of the situation; the office visits and associated modalities are excessive, and not reasonable and necessary.
5. Application of surface neuro-stimulator. Please see #1 above.
6. Special reports – By my reading the special reports were paid. The exact nature of this request is unclear.
7. Whirlpool therapy – the date of the requested passive therapy is nearly three years after the date of injury. At best this is palliative and not reasonable and necessary care for the injury sustained. As noted by discogram, there is a disc lesion in terms of an annular tear and the whirlpool will not treat that lesion. Thus, this is not reasonable and necessary to treat the injury. Moreover, similar result can be achieved in ones own home bathtub. There is no requirement for the therapy offered.
8. Joint mobilization – Again, the lesion has been noted. The annular tear will not resolve or improve as a result of joint mobilization. The Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters states that repetitive use of acute measures generally foster and encourages physician dependence, illness behavior, chronicity, and over utilization. Thus, as per the parameters established by the professional organization of the provider, the treatment plan pursued is excessive on its face.
9. Manual traction – See #7 above.