MDR Tracking Number: M5-03-2256-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 5/9/03.

The requestor sent in a withdrawal for date of service 6/12/02, therefore, this date will not be reviewed further in this Finding and Decision.

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 following dates of service were found to be medically necessary:

a) Office visits: total of 6, one per month (6/20/02, 7/19/02, 8/5/02, 9/10/02, 10/29/02, 11/8/02).
b) Physical therapy sessions (including ultrasound, massage, hot/cold packs, electrical stimulation, therapeutic procedure, neuromuscular reeducation and therapeutic activities on the 6/13/02, 6/18/02, 7/1/02, 7/8/02, 7/11/02, 8/2/02, 8/5/02, 8/12/02, 8/16/02, 8/20/02, 8/26/02, 8/27/02, 8/30/02, 9/3/02, 9/5/02, 9/9/02, 10/4/02, 10/7/02, 10/8/02, 10/11/02, 10/14/02, 10/15/02, 10/21/02, 10/22/02, 10/25/02, 10/28/02, 11/1/02, and 11/4/02.

The remaining treatments rendered were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for these office visits and physical therapy charges.

This Finding and Decision is hereby issued this 25th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division

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 6/13/02 through 11/8/02 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 25th day of August 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/crl

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 1, 2003

RE: MDR Tracking #: M5-03-2256-01
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 Medicine physician reviewer. The Chiropractic Medicine 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 claimant is a 21-year-old "washateria attendant" for the _____. Reportedly, the claimant sustained injuries to her left wrist, left knee and low back, secondary to a slip and fall. According to the documentation of a _____, the claimant was mopping the floor when she slipped and fell forwards onto her wrist and knee. While trying to get up she slipped again and landed on her low back.

_____ is the attending in this case. His initial evaluation is remarkable for inflammation of the left wrist and restricted range of motion. The claimant's knee is also inflamed and exhibits restricted range of motion. McMurray's test is positive for crepitus. The claimant's lumbar spine exhibits muscle spasm, restricted range of motion and referral of symptoms with orthopedic testing. Plain film radiology is most remarkable for a loss of the normal lumbar lordosis. _____ arrives at the following impressions:

1. Lumbar sprain / strain.
2. Muscle spasm.
3. Wrist sprain.
4. Knee sprain.

is initial plan called for passive therapy, daily for two weeks. The medical reflects that the claimant underwent 6 weeks of passive modalities exclusively.

The medical reflects that the claimant underwent multiple MRI studies on 7/1/02. MRIs of the left wrist and knee are most remarkable for "small joint effusion." An MRI of the lumbar spine reveals: L4-5 partial desiccation of the disc material with 4 mm broad central disc herniation indenting the dural sac. The L5 nerve root is obliterated. There is 50% foraminal stenosis due to facet hypertrophy and bulging annulus.

A _____ is consulted on 7/1/02. _____ reports electromyographic evidence of bilateral L5 radiculopathy and/or peripheral neuropathy. His impressions include lumbar disc derangement and internal derangement of left knee.

The claimant undergoes a psychological evaluation on 7/1/02. _____, finds that the claimant is suffering from reactive depression and post injury low back pain. He recommends work hardening.

A _____ is seen on 7/31/02 for an orthopedic consultation. He arrives at impressions concurrent to the attending and recommends rehab and injections.

The claimant begins active care at the office of _____ on 8/1/02.

A _____ performs a peer review on this case on 8/5/02. In summary he feels this type of injury should have resolved in six to eight weeks. He concludes that the initial passive therapy was excessive. He also feels that the claimant should be able to return to work in some capacity.

The claimant begins a series of epidural steroid injections on 8/27/02. The procedure is accompanied by outpatient kinetic activities, neuromuscular re-education and therapeutic exercises at the office of the attending. This approach is repeated in September and October of 2002. The attending performs functional capacity evaluations on the claimant on 8/27/02 and 10/30/02. Eight weeks of active rehabilitation and three epidural steroid injections have gained the claimant minimal increases in active range of motion and moves her from a sedentary to light physical demand capacity. In reviewing these dates of service, the attending's chart notes are nonspecific and redundant. The claimant's pain level on 6/14/02 was an 8/10. On 10/29/02 the claimant's pain is a 6/10.

The claimant undergoes an independent medical exam with a _____on 11/20/02. Objective findings include soft tissue tenderness around L5. There is noted no paraspinal muscle spasm. The remainder of the exam was unremarkable. _____ feels that there is no indication for a continuance of chiropractic care. He recommends the claimant lose weight and return to work. No other documentation was available.

Requested Service(s)

The services in question were rendered from 6/13/02 through 11/8/02. Services included: minimal office visits, hot/cold packs, required report, therapeutic activities, therapeutic exercises and neuromuscular re-education. Total number of visits: 60.

Decision

I must agree with the carrier, in part, in that the services rendered from 6/13/02 through 11/8/02 were largely medically unnecessary and unreasonable.

Authorized: PT sessions of 6/13/02, 6/18/02, 7/1/02, 7/3/02, 7/8/02, and 7/11/02, excluding office visit codes 99211. (These are all passive therapy.) Additionally, PT sessions on 8/2/02, 8/5/02, 8/12/02,

8/16/02, 8/20/02, and 8/26/02, excluding office codes 99211. (These are active therapy with additional passive modalities.) In conjunction with ESI on 8/27/03, PT sessions of 8/27/02, 8/30/02, 9/3/02, 9/5/02, and 9/9/02. In conjunction with ESI on 9/27/03, PT sessions on 10/4/02, 10/7/02, 10/8/02, 10/11/02, 10/14/02, and 10/15/02. In conjunction with the ESI on 10/16/02, PT sessions on 10/21/02, 10/22/02, 10/25/02, 10/28/02, 11/01/02, and 11/4/02. (Office visit codes during the post-ESI therapy are excluded.) Office visit codes 99211 are reasonable and necessary once monthly, during ongoing physical therapy, for a maximum of 6 charges.

Not authorized: All remaining PT dates and excessive office visit codes.

Rationale/Basis for Decision

The claimant's injuries were documented and found to be compensable. Injuries to the wrist, low back and knee were substantiated. The attending entered into a course of care. According to TWCC Spine Treatment Guidelines, "unattended modalities should be limited to a maximum of two weeks, if used solely." This is consistent with the literature. Considering the multiplicity of the injuries sustained, the continued use of passive modalities for an additional two weeks is not unreasonable, so long as the procedures are accompanied by therapeutic procedures (McKenzie Protocols). I note no medical rationale for "daily visits" for two weeks, however, most notably when the "daily visits" are interrupted by the weekend. Four weeks of passive care, at three sessions per week, was not unreasonable; however integrating self help exercises in conjunction with therapy is more appropriate. I see no medical need for a total of six weeks of passive care exclusively. The MRI of the lumbar spine was remarkable for discopathy, stenosis and foraminal compromise. Why the claimant did not see an orthopedist for another month is not understood. The epidural steroid injections were reasonable. Active rehabilitation during the course of epidural steroid injections is also reasonable. However, utilizing some 29 sessions over a three month period is not. The frequency of visits should have decreased as the claimant progressed. With the extent of rehab that she had undergone, the claimant should have been well versed in a home based exercise program. Her dependence with outpatient care should have decreased over time.

In summary, 6 sessions of passive care exclusively is reasonable. An additional 6 sessions of passive care, in conjunction with active care is also reasonable. Active care and/or rehabilitation while the claimant underwent the epidural steroid injections was also reasonable, for a maximum of 6 sessions/2 weeks. However, the frequency of visits should have decreased over time. Twelve sessions of aggressive rehabilitation over a four week period would have been reasonable. An additional 6 sessions over a four to six week period, monitoring the claimant's return to the work place would also have been reasonable, however, these overlap with post-ESI sessions, after the 3rd injection. These 30 sessions of physical medicine suggested would have been reasonable for the injuries sustained. Any additional sessions thereafter, are considered excessive, medically unnecessary and/or unreasonable.

The opinions rendered in this case are the opinions of this evaluator. This evaluation has been conducted on the basis of medical documentation as provided with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports, or reconsideration may be requested. Such information may or may not change the opinions rendered in this evaluation. This opinion is based on a clinical assessment from the documentation provided. This opinion does not constitute, per se, a recommendation for specific claims or administrative functions to be made or enforced.