THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-04-0146.M5

MDR Tracking Number: M5-03-2304-01

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 (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent.

The requestor submitted a medical dispute resolution request on 5/13/03 and was received in the Medical Dispute Resolution on 5/13/03. The disputed dates of service from 4/5/02 through 5/10/02 are not within the one-year jurisdiction in accordance with Rule 133.308(e)(1) and will be excluded from this Finding and Decision.

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 the office visits with manipulations, massage therapy, unlisted DME, myofascial release and reports 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 the office visits with manipulations, massage therapy, unlisted DME, myofascial release and report 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 5/15/02 to 2/14/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 12th day of August 2003.

Carol R. Lawrence
Medical Dispute Resolution Officer
Medical Review Division
CRL/crl

July 29, 2003

IRO Certificate# 5259
MDR Tracking Number: M5-03-2304-01

An independent review of the above-referenced case has been completed by a chiropractic doctor. 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

Based on materials provided for review, it appears that this patient experiences a low back injury while at work on ___ while lifting fiberglass. He presents initially for chiropractic treatment with ___, on 7/11/01. An MRI appears to be ordered in addition to spinal manipulation and multiple passive modalities. Lumbar MRI of 7/21/01 suggests degenerative disc disease at multiple levels. A lumbar electrodiagnostic evaluation provided by ___, from 8/24/01 suggest S1 sensory radiculopathy to the left leg and foot. A lumbar CT is provided 10/23/01 suggesting mild central disc protrusions and degenerative disc disease. A functional capacity evaluation is performed 9/5/01 by ___ suggesting that the patient is at light work or sedentary work capacity. The patient is referred for neurosurgical consultation with ___, on 1/25/02 and is not found to be a surgical candidate. The patient is then referred for aggressive physical medicine management with ___. ___ report of 2/31/02 suggests that the patient is unresponsive to epidural steroid injections, chiropractic care and medication. The patient is then referred for chronic pain management and functional restoration with the ___ program in ___. Multiple reports and notes are submitted from ___ and the ___ program from 1/31/02 to 5/1/03. ___ occupational therapy notes from 4/24/02 suggest that overall discharge functional goals are met for strength and endurance and a written home program is issued and reviewed with patient. The patient is released to full time work with temporary limitations on 5/1/02. Medications are given for arthritic disorders and assistance with sleep. Chiropractic care is resumed utilizing manipulation and myofascial release modalities. Analogue pain scale from chiropractic notes suggest essentially unchanged levels at between 5-7 out of 10 as the worst possible pain. All subjective self-assessment forms submitted suggest that patient is the 'same' or essentially unchanged from visit to visit. The patient is seen again for impairment evaluation by ___ on 6/9/02. At this time, he is found at MMI with 10% WP impairment levels. Chiropractic treatment and SOAP notes

are provided for 4/5/02 through 2/14/03 only. Chiropractic notes submitted from 11/22/02 to 2/14/03 suggest that patient is seen at approximately 2 xs per month for lumbar spinal manipulation only. There appears to be no report of exacerbation, re-injury, or other complications.

REQUESTED SERVICE (S)
Medical necessity and appropriateness of treatment of office visits with manipulations, massage therapy, unlisted DME, myofascial release, special reports.

DECISION
Documentation does not support the medical necessity of the disputed treatments and modalities. Uphold denial.

RATIONALE/BASIS FOR DECISION
Ongoing office visit/spinal manipulation applications 99213-MP appear to be provided on a weekly basis from 5/15/02 through 1/2/03. They are then decreased to approximately 2x per month from 1/6/03 to 1/14/03. There does appear to be some clinical rationale for supportive care with manipulative procedures on an as needed basis. However, no specific exacerbation, re-injury, or other acute aggravation of conditions is documented. There is little rationale in this file supporting supportive care with manipulation at greater than 2x per month to establish RTW restoration of function. This file contains no clinical rationale or documented medical necessity for 97124 massage services, 97250 myofascial release or unlisted DME services. There are no specific documents dated 10/4/02 that justify the charge of 99080 special reports.

[TWCC Spine Treatment Guidelines, AHCPR Low Back Treatment Guidelines, and GCQAPP Mercy Center Consensus Conference] 1990 RAND Consensus Panel: 'a trial course of two weeks each using alternative manipulative procedures before considering treatment/care to have failed. Without evidence of improvement over this time frame, spinal manipulation is no longer indicated.'

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review.

This review and its finding are based solely on submitted materials. No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned claimant. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.