

MDR Tracking Number: M5-03-2340-01

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 5/14/03 and was received in the Medical Dispute Resolution on 5/19/03. The disputed dates of service from 4/22/02 through 5/19/02 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 and physical therapy treatments, including therapeutic procedures, neuromuscular stimulation, aquatic therapy, electrical stimulation, ultrasound, hot/cold packs, mechanical/manual traction, myofascial release and physical performance tests 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 and physical therapy treatment 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 5/20/02 to 7/22/02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 31<sup>st</sup> day of July 2003.

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

July 24, 2003

IRO Certificate# 5259  
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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 is a gentleman who sustained a lumbar injury on \_\_\_\_. One month later he was seen by a chiropractor who obtained an MRI of the lumbar spine the same day. A mild bulge that was not neuro-compressive was noted at the L4-5 and L5-S1 levels. There was a question of a hernia; however, examination by a Board Certified general surgeon could not provide any evidence of a hernia. In the first four months of this injury, there were 60 chiropractic visits and there is no documentation in the hand written notes demonstrating any improvement in the overall condition of this claimant. There was a five-month gap in care and in the ensuing three months (May-July), there was an additional 37 visits for chiropractic care. Quasi electrodiagnostic testing was completed on May 10. On May 29, 2002 there was a referral and physical therapy assessment that included range of motion testing for impairment rating. Additional physical therapy (not chiropractic) was completed between June 19, 2002 and July 22. At the same time a Designated Doctor assessment was that the claimant was not at maximum medical improvement.

#### REQUESTED SERVICE (S)

1. Therapeutic procedures
2. Neuromuscular stimulation
3. Aquatic therapy
4. Electrical stimulation
5. Ultrasound
6. Hot/Cold Packs
7. Mechanical traction
8. Manual Traction
9. Myofascial release
10. Physical performance tests
11. Office visits
12. Required reports 5/20/02-7/22/02 medically necessary

#### DECISION

This treatment was not clinically indicated, was excessive and not reasonable and necessary for the injury sustained.

#### RATIONALE/BASIS FOR DECISION

The medical treatment in question was palliative in nature and the modalities provided by the chiropractor are not reasonable or necessary at this point in the rehabilitative cycle of the claimant. The accuracy of the tests performed has not been supported by

the peer-reviewed literature. The repetitive and ongoing use of hot/cold packs, ultrasound, electrical myostimulation, myofascial release, massage, joint mobilization, mechanical and manual traction and other passive modalities has been shown to contribute to the chronicity of the patient's subjective complains while at the same time nurturing the development of physician dependence, illness behavior, an over utilization. (Guidelines for chiropractic Quality Assurance and Practice Parameters, 1993.) Moreover also as noted by Haldeman, cases resolve well within six weeks of intervention. The treatment plan offered is not effective and would be considered excessive and should be discontinued. It is surprising that the practitioner in this case would pursue such protracted palliative care when any lasting benefit is elusive. The progress notes provided do not indicate any substantial improvement. 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 improvement. The chiropractic care with respect to this individual claimant has been excessive by any standard. Daily or weekly manipulations and palliative passive modalities cannot be continued indefinitely 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.

The chiropractic care after two months that yielded little benefit should have been modified to more definitive treatment. It is surprising that a practitioner would pursue continued treatment for such an extended length of time when improvement is elusive.

The Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters states that repetitive use of acute care measures generally foster and encourages physician dependence, illness behavior, chronicity, and over-utilization.

The efficacy of manipulations can be effective in the first month of acute back symptoms without radiculopathy. However, for patients with symptoms lasting longer than one month, its efficacy is unproven. If manipulation has not resulted in a functional and symptomatic improvement after four weeks, it should be stopped.