MDR Tracking Number: M5-03-2822-01

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 7/7/03.

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 chiropractic care utilizing passive therapy, office visit and therapeutic exercise for the first 4 weeks of the injury (DOS 8/13/02), and office visits and active kinetic exercise (therapeutic exercise, neuromuscular re-education) from 8/13/02 through 12/20/02 **were** found to be medically necessary. The passive therapies (electric stimulation, hot/cold packs, myofascial release, ultrasound and joint mobilization) were not medically necessary for treatment after 8/19/02. The respondent raised no other reasons for denying reimbursement for chiropractic care utilizing passive therapy, office visit and therapeutic exercise for the first 4 weeks of the injury (DOS 8/13/02), and office visits and active kinetic exercise (therapeutic exercise, neuromuscular re-education) from 8/13/02 through 12/20/02.

This Finding and Decision is hereby issued this 12th day of September 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 8/13/02 through 12/20/02 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 12th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/crl

REVISED 09/05/03

August 18, 2003

MDR Tracking Number: M5-03-2822-01
IRO Certificate# 5259

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

Documentation available from file suggests that this individual was injured at work on ___ while lifting a box during his regular course of employment. He presents the same day to his chiropractor; ___ with complaints of low back pain and pain radiating into his lower extremities. No x-rays are obtained at this time, but the patient is diagnosed with Lumbar/S1 joint sprain and strain with myospasm and possible HNP. The patient is treated with multiple passive modalities at 3-5x per week with 4-week re-examination anticipated in order to determine necessity for further care. Chiropractic SOAP notes are supplied from 8/13/02 to 12/20/02 only. No 4-week re-examination report is provided for review. Chiropractic notes suggest that manipulation and only passive modalities are provided from 7/11/02 to 9/26/02. Passive modalities in addition to 2 units of active therapy appear to be applied from 9/27/02 to 12/20/02. A pain management evaluation is made with ___, on 8/19/02. These findings suggest possible disc herniation at L5/S1.

Recommendations include MRI study and a series of epidural steroid injections under fluoroscopy. Oral pain medications are provided with recommendations for active kinetic exercise at 3x per week for four weeks.

A neurosurgical evaluation is made 10/3/02 with ___ suggesting need for surgical correction of L5/S1 disc herniation confirmed by MRI of 8/22/02. EMG studies are reported to be normal. No surgical or operative report is provided for review. There is an 11/21/02 follow-up report submitted by treating chiropractor, ___, suggesting that patient undergo post surgical passive modalities for 12 sessions.

REQUESTED SERVICE (S)

Medical necessity for chiropractic services (therapeutic exercise, office visits, myofacial release, electric stimulation, neuromuscular re-education, joint mobilization, aquatic therapy, hot & cold packs) rendered from 8/13/02 through 12/20/02.

DECISION

Based on available documentation, there does appear to be rationale for conservative care within the first four weeks following this reported injury. Appropriate advanced imaging and neurosurgical consultation would have been indicated as soon as discopathy and /or radiculopathy were suspected. As there are no chiropractic notes or reports submitted from this period, specific medical necessity for these services cannot be determined. Medical assessment of 8/19/02 suggests that active kinetic exercise was indicated as physical therapy at this point. Some level of post-surgical physical therapy and rehabilitation does appear indicated, however, there is no indication that this should exceed 4 weeks duration unless specifically requested by surgeon based on objective functional deficits. No specific functional deficits are noted in chiropractic reporting.

Medical necessity supports chiropractic care utilizing passive therapy, office visits and therapeutic exercise for the first 4 weeks following injury (7/11/02 – 8/19/02). There is no documentation supporting medical necessity for ongoing passive treatment at these levels beyond this period, as this appears to be a surgical condition. There is medical necessity supporting active rehabilitation (therapeutic exercise) for up to 4 weeks post-surgery (11/21/02 – 12/20/02). However, continuation of this program would have required surgical recommendation and objective qualification of functional deficits (not provided).

Passive therapies (electric stimulation, hot/cold packs, myofascial release, ultrasound, and joint mobilization) are **not** medically necessary for treatment after 8/19/02. Medical necessity **is supported** for office visits and active kinetic exercise (therapeutic exercise, neuromuscular re-education) from 8/13/02 through 12/20/02 only.

This file contains no documentation suggesting that aquatic therapy was ever ordered or performed by treating chiropractor; therefore medical necessity was not established.

RATIONALE/BASIS FOR DECISION

[AHCPR Low Back Pain Treatment Guidelines, GCQAPP Mercy Center Consensus Conference, 1990 RAND Consensus Panel]

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 medial/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 or request. If more information becomes available at a later date, and additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review and its findings 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.