MDR Tracking Number: M5-03-3180-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 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 08-04-03.

The IRO reviewed office visits, manual traction, electrical stimulation, myofasical release, therapeutic procedures, and hot or cold packs rendered from 08-06-02 through 08-29-02 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity for ten office visits, manual traction, electrical stimulation, myofasical release, therapeutic procedures, and hot or cold packs. Consequently, the requestor is not owed a refund of the paid IRO fee.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for two office visits rendered between 08-06-02 through 08-29-02. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

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 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 10-24-03, 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.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Maximum Allowable Reimbursement)	Reference	Rationale
08-30-02	99213MP	$60.00	0.00	No EOB	$48.00	MFG, MGR (I)(B)(1)(b)	Soap notes do not confirm delivery of services. Reimbursement is not recommended
	97110 (4 units)	$140.00			$35.00 per unit	MFG, MGR (I)(A)(9)(b)	
	97250	$45.00			$43.00	MFG MGR (I)(C)(3)	
	97122	$35.00			$35.00	MFG, MGR (I)(A)(10)(a)	
	97014	$22.00			$15.00	MFG MGR (I)(A)(9)(a)(ii)	

TOTAL	$302.00		The requestor is not entitled to reimbursement

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for 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 Decision is applicable for two office visits between dates of service 08-06-02 through 08-29-02 in this dispute.

This Decision is hereby issued this 5th day of April 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 1, 2004

RE: MDR Tracking #: M5-03-3180-01
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 physician reviewer who has a temporary ADL exemption. The Chiropractic 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

It appears the claimant injured his low back and possibly left shoulder while lifting a desk onto a truck on ___. It appears the desk began to fall and in order to keep the desk from falling, he had to grab onto the desk and this caused his low back to reportedly hyperextend and he felt and heard a pop in his low back. The claimant began seeing ___ fairly soon after the injury and was diagnosed mainly with thoracic and lumbar sprain/strain injuries along with muscle spasm. The claimant reported left shoulder and neck pain; however, this was not reported with any type of increased frequency in the overall documentation. It appears that the left shoulder and neck injuries were of little consequence from a treatment perspective. The claimant has undergone extensive amounts of chiropractic care. He has undergone a lumbar discogram. Work conditioning and work hardening have been repeatedly denied through the pre-authorization process. The claimant has remained off work for quite some time.

There were 3 functional capacity exams provided for review. These took place on 6/18/02, 8/21/02 and 4/24/03. According to the functional capacity exam report of 4/24/03, the claimant was required to function at the medium duty level; however, it has been repeatedly documented by ___ and her attorney that the claimant is required to function at the very heavy-duty level. A designated doctor saw the claimant on at least 3 occasions and her name was ___. The claimant was finally certified at maximum medical improvement on 1/8/03 and given 4% whole person impairment rating mainly for range of motion deficits in the left shoulder. The review of the functional capacity exams did reveal very little change in the claimant's condition and he seemed to remain at the medium heavy to heavy duty level throughout the testing. Multiple peer reviews have stated there was no observed improvement in the claimant's condition to substantiate much of the chiropractic care. An MRI of the lumbar spine revealed a right paracentral L4/5 disc protrusion that was lateralizing toward the right; however, caused no foraminal encroachment. There was a lumbar disc bulge at L5/S1. Multiple daily chiropractic notes beginning on 3/25/02 onward were reviewed. A left shoulder MRI was essentially normal with respect to any type of injury related pathology. There were shoulder findings; however, after review of these findings, it was my opinion the findings were mostly related to degenerative changes and other conditions not related to the injury. The claimant also appeared to have various arm and finger complaints including numbness and tingling. He reported no numbness and tingling in the left lower extremity although he did report some initial right sided leg pain. The claimant was begun on some active care, I believe sometime in early July 2002; however, the first documented evidence of active care occurred on 7/10/02. Prior to this date, the claimant did report that he had some increased discomfort with exercising so I assume that some active care was begun prior to this; however, I cannot determine from the documentation exactly when the active care was initiated. By my count the claimant had undergone approximately 77 chiropractic visits of passive and active care from 3/25/02 through 8/6/02. The 8/6/02 date is the first date of the disputed services and is the subject of this IRO. The designated doctor reports from ___ were carefully reviewed. The claimant was felt not to be at maximum medical improvement as of 8/21/02 mainly based on what appeared to be shoulder deficits and left arm weakness. It was my opinion that ___ based her non-determination of maximum medical improvement on non-injury related factors. It was also documented on that date that the claimant was able to bend over in a seated position from a chair and take his shoes and socks off without apparent difficulty. This would be extremely difficult to do if there were significant internal disc derangement. ___ saw the claimant for orthopedic evaluation on several occasions and by 8/27/02 he was recommending that the claimant undergo epidural steroid injections. ___ repeatedly stated the claimant continued to fatigue easily with exercises and the exercises seemed to reproduce and aggravate his low back pain. ___was selected by ___ to evaluate the claimant on 10/22/02 and his exam was reviewed. It was stated that ___ care had been beneficial; however, there was no objective basis for this opinion. Continued conservative care was recommended with the possibility of pain management including epidural steroid injections and facet injections, as well as a work hardening program. The attorney for ___ submitted a report and I will address this report in the rationale section of this report below.

Requested Service(s)

The medical necessity of the outpatient services including electric stimulation, office visits, therapeutic procedures, myofascial release, manual traction and hot or cold packs from 8/6/02 through 8/29/02.

Decision

I agree with the insurance carrier and find that the services as listed above were not medically necessary with the exception of office visits on 2 occasions from 8/6/02 through 8/29/02.

Rationale/Basis for Decision

As ___ was the treating physician of record and based on the fact that the claimant continued to see ___ after 8/29/02 it is my opinion that the office visits which were billed during this time at a reasonable frequency of once every 2 weeks would be considered reasonable and medically necessary for monitoring purposes and for the making of referrals. No more than 2 office visits over this time period would have been considered reasonable or medically necessary. Any and all other treatment besides 2 office visits from 8/6/02 through 8/29/02 would be considered medically necessary. I cannot really comment on exactly what date the office visit would be considered reasonable and necessary; however, suffice it to say that 2 office visits over a 24 day period would be reasonable at that particular juncture to monitor the claimant's condition and make referrals. The claimant was also not certified to be at maximum medical improvement until 1/8/03 and this would also rationalize 2 office visits during that time period of 8/6/02 through 8/29/02. The office visits should be office visits only without treatment or manipulative care. By my count the claimant had received about 77 chiropractic visits of passive and some active physical therapy by or as of 8/6/02 stemming back from 3/25/02. I am unaware of any treatment guideline, evidence based or consensus based, which condones this amount of treatment without objective evidence of improvement. There were many instances in the documentation in which there is vague reference to improvements or that the claimant had benefited from the care rendered; however, I saw no objective evidence of this alleged improvement. The claimant's subjective low back pain remained at a constant 6/10-pain level throughout much of the documentation. The issue here is not whether the claimant had reached maximum medical improvement in a timely fashion or that he had too much care. In fact ___ stated in his peer review that the claimant was not at maximum medical improvement. ___ was not trying to state the claimant was at maximum medical improvement he was simply saying that another approach was needed and I would definitely concur with that opinion. The issue at this point of the disputed services of 8/6/02 through 8/29/02 was whether or not enough progress had been shown up through that date to justify further treatment and/or if another approach to treatment needed to be taken due to lack of progress under the current treatment plan. The mere presence of ongoing dysfunction, derangement, or symptoms without improvement or progression through the current treatment plan always demands a new treatment plan or approach. The services in question which run from 8/6/02 through 8/29/02 represent the same treatment approach as to what was essentially going on over the prior 77 visits. It is not reasonable or medically necessary to beat a dead horse so to speak if the current approach to treatment at any given time is not documented to be effective. The Mercy Conference Guidelines as well as the highly evidence based Official Disability Guidelines define a trial of care to be anywhere from 6-12 visits over a 4 week period. This claimant received 77 chiropractic visits through 8/6/02 and was not documented to have progressed. In fact the functional capacity exams of 6/18/02 and 8/21/02 show absolutely no change in the claimant's condition. In fact there were digressions in some of the areas. The 4/24/03 functional capacity exam shows the claimant's strength remained very good at the medium heavy to very heavy duty level. The only area where the claimant digressed was in his cardiovascular area. It is not reasonable for the claimant to continue daily chiropractic care in order for his cardiovascular status to be maintained. The claimant can maintain a cardiovascular status quite well on his own via a routine exercise program. The claimant's strength, which appeared to be very adequate, would have served to help him maintain a decent cardiovascular status on his own. Also, just because an orthopedic specialist recommends daily care does not justify daily care. Daily care is rarely indicated and if it is indicated then it is usually only indicated in the first 1-2 weeks during the acute stage of the injury or perhaps immediately following the initiation of a post surgical treatment program. Also please consider the functional capacity exams of 6/18/02, 8/21/02 and 4/24/03. There was really no documented change in the claimant's functional status through these testing periods. The claimant has demonstrated a consistent medium heavy to heavy duty level of function since 6/18/02 and by that date the claimant had more than ample chiropractic treatment without a change in the treatment plan.

It was clear that the chiropractic care rendered from 8/6/02 through 8/29/02 did nothing to enhance this claimant's ability to retain employment and did not serve to increase his objective level of function any better than had he continued on a routine home based exercise program. ___ attorney mentions several issues that need to be addressed. First of all there is some discrepancy between what the exact level of function the claimant is required to function. In other words, the functional capacity exam of 4/24/03 stated he was required to function at the medium duty level; however, it has been maintained by other physicians and documentation that the claimant is required to function at the very heavy duty level. This issues needs to be addressed. It does not matter at what required level of function he is to function and this would not change any of my opinions because if indeed the claimant was required to function at the medium duty level, then he should have been released to return to work a long time ago. If indeed the claimant was required to function at the very heavy duty level, it was still clear that the current treatment plan was not helping the claimant progress since obviously he has been at the same level since 6/18/02. Also I have already addressed this issue; however, just because an orthopedic specialist recommends daily physical therapy does not make it reasonable or necessary. I am unaware of any treatment guideline which recommends this amount of intensive care without evidence of objective change. ___ attorney also stated that the April 2003 functional capacity exam represented a decline in the claimant's condition. This is not entirely true. The claimant's strength actually increased overall; however, his cardiovascular level went down to the sedentary level. This would not be because the claimant did not receive necessary treatment. The claimant's cardiovascular condition could have been maintained through a routine walking or exercise program to be done at home. The claimant obviously demonstrated sufficient strength such that he could have maintained a decent cardiovascular profile. The claimant's decreased cardiovascular profile as of April 2003 had nothing to do with the lack of treatment. Please also consider that the claimant weighed anywhere from 250-260 pounds and this would indicate to me that he was about 50-70 pounds overweight given his height of 5'10". The claimant was not likely the picture of cardiovascular fitness prior to the injury. Again the issue was not whether or not the claimant was at maximum medical improvement, the issue was whether or not the treatment rendered had sufficiently progressed the claimant such that further treatment along the same treatment plan was needed or warranted. Again the claimant underwent 77 chiropractic visits prior to the beginning of the disputed services of 8/6/02. This is way out of line and there obviously needed to be a change in the treatment plan or approach. Again the mere presence of symptoms and ongoing dysfunction do not justify ongoing treatment along the same treatment plan.