

MDR Tracking Number: M5-04-0792-01

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, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, 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 11-13-03. The disputed dates of service 11-8-02 through 11-11-02 are untimely and ineligible for review per TWCC Rule 133.307 (d)(1) which states that a request for medical dispute resolution shall be considered timely if it is received by the Commission no later than one year after the dates of service in dispute. The Commission received the medical dispute on 11-13-03.

The IRO reviewed therapeutic exercises; office visits w/manipulations, neuromuscular re-education, joint mobilization, myofascial release, and mechanical traction from 11-13-02 through 12-18-02.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO concluded that the therapeutic exercises, office visits w/manipulations, and neuromuscular re-education from 11-13-02 through 12-18-02 **were** medically necessary. The IRO agreed with the previous adverse determination that the joint mobilization, myofascial release, and mechanical traction **were not** medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. 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.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 3-9-04, 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	MARS (Max. Allowable Reimbursement)	Reference	Rationale
11/13/02	97265	\$50.00	\$0.00	F	\$43.00	Rule 133.307(g)(3) (A-F)	Relevant information supports delivery of service. Recommend reimbursement of \$43.00 x 3 DOS = \$129.00.
11/15/02	97265	\$50.00					
11/18/02	97265	\$50.00					

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Max. Allowable Reimbursement)	Reference	Rationale
TOTAL		\$150.00	\$0.00				The requestor is entitled to reimbursement of \$129.00.

This Decision is hereby issued this 28<sup>th</sup> day of April 2004.

Dee Z. Torres  
 Medical Dispute Resolution Officer  
 Medical Review Division

**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 Order is applicable for dates of service 11-13-02 through 12-18-02 in this dispute.

This Order is hereby issued this 28<sup>th</sup> day of April 2004.

Roy Lewis, Supervisor  
 Medical Dispute Resolution  
 Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

March 4, 2004

MDR Tracking #: M5-04-0792-01  
 IRO Certificate #: IRO4326

The \_\_\_ 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 rendered 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 matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. \_\_\_'s health care professional 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

This patient sustained an injury on \_\_\_ when he was thrown onto the ground from a forklift, approximately four feet. He reported bilateral lumbar pain. An MRI performed 10/25/02 revealed a disc herniation at L4-5 pressing on the anterior thecal sac. He underwent lumbar epidural injections, physical therapy, chiropractic treatments, and muscle relaxant and anti-inflammatory medications.

#### Requested Service(s)

Therapeutic exercises, office visits with manipulation, neuromuscular re-education, joint mobilization, myofascial release, and mechanical traction from 11/13/02 through 12/18/02

#### Decision

It is determined that the therapeutic exercises, office visits with manipulation, and neuromuscular re-education from 11/13/02 through 12/18/02 were medically necessary to treat this patient's condition. However, the joint mobilization, myofascial release, and mechanical traction from 11/13/02 through 12/18/02 were not medically necessary to treat this patient's condition.

#### Rationale/Basis for Decision

The use of therapeutic exercises and neuromuscular rehabilitation from 11/13/02 to 12/18/02 were necessary for the treatment of this patient. Haldeman et al indicate that it is beneficial to proceed to the rehabilitation phase of care as rapidly as possible to minimize dependence on passive forms of treatment/care and reaching the rehabilitation phase as rapidly as possible and minimizing dependence on passive treatment usually leads to the optimum result. (*Haldeman, S., Chapman-Smith, D., and Petersen, D., Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen, Gaithersburg, Maryland, 1993*)

The use of manipulation was indicated in light of the patient's improvements in symptomatology noted in the progress notes.

The use of joint mobilization was not warranted. The concomitant use of joint mobilization and manipulation on the same visit represents duplication of services, as the manipulation incorporates joint mobilization as one on the key components in the procedure.

The provider utilized passive physical therapy modalities and procedures, myofascial release and mechanical traction, from 11/13/02 to 12/18/02 which were not indicated. The Philadelphia Panel found that therapeutic exercises were found to be beneficial for chronic, subacute, and post-surgery low back pain. Continuation of normal activities was the only intervention with beneficial effects for acute low back pain.

For several interventions and indications (e.g., thermotherapy, therapeutic ultrasound, massage, electrical stimulation), there was a lack of evidence regarding efficacy. (*“Philadelphia Panel Evidence-Based Guidelines on Selected Rehabilitation Interventions for Low Back Pain”*. *Physical Therapy*. 2001;81:1641-1674).

The Agency for Health Care Policy and Research: Clinical Practice Guideline Number 14, “Acute Low Back Problems in Adults” indicates that “the use of physical agents and modalities in the treatment of acute low back problems is of insufficiently proven benefit to justify its cost”. They did note that some patients with acute low back problems appear to have temporary symptomatic relief with physical agents and modalities. Therefore, the use of passive physical therapy modalities (hot/cold packs, electrical stimulation) is not indicated after the first 2-3 weeks of care.

There are now 24 RCTs of various forms of traction in neck and back pain but they are generally of poor quality. Traction does not appear to be effective for low back pain or radiculopathy. In addition, the Royal College of General Practitioners indicate that, although commonly used for symptomatic relief, these passive modalities (ice, heat, short wave diathermy, massage, ultrasound) do not appear to have any effect on clinical outcomes (*Royal College of General Practitioners, Clinical Guidelines for the Management of Acute low Back Pain, Review Date: December 2001*). Therefore, it is determined that the therapeutic exercises, office visits with manipulation, and neuromuscular re-education from 11/13/02 through 12/18/02 were medically necessary. However, the joint mobilization, myofascial release, and mechanical traction from 11/13/02 through 12/18/02 were not medically necessary.

Sincerely,