

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 December 4, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

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 mechanical traction and 2 units only of therapeutic exercises for 01-15-03, 01-17-03, 01-21-03, 02-06-03 and 02-11-03 were found to be medically necessary. The office visits with manipulation, neuromuscular re-education in excess of that approved above, electric stimulation, myofascial release, therapeutic exercises in excess of that approved above, mechanical traction, and joint mobilization for 12-20-02 through 02-11-03 were not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

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 01-15-03 through 02-11-03 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 9th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 23, 2004

MDR Tracking #: M5-04-0991-01
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 reviewer who has an ADL certification. The 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

According to the documentation provided for review, which is quite voluminous, the claimant was in the process of loading and unloading onto and out of an 18-wheeler which was backed up to a dock. It appears the truck rolled forward slightly thus causing a gap between the dock and the truck and this caused the forklift which the claimant was driving to fall into this gap and further causing the claimant to fall off the forklift onto the ground some 4-6 feet below. The forklift later fell; however, the claimant was able to get out of the way of the falling forklift. The claimant presented for chiropractic care on 9/17/02 complaining of 10/10 level low back pain which caused radiation into both buttocks and legs. The claimant was also complaining of 9/10 level neck pain as well as 7/10 level shoulder pain. It appears, however, that the claimant's main problem was at the low back. The claimant did undergo an MRI evaluation of the lumbar spine and this revealed there to be 2-3mm disc herniations that reportedly touched the thecal sac at the L4/5 and L5/S1 levels. There was really no mention at all of any type of direct neural compression at the central canal or foramen bilaterally. The claimant had alleged electrodiagnostic evidence of bilateral lumbar radiculopathy at the L4 through S1 levels and again this was on both sides. The radiculopathy was felt to be either of early onset or extremely mild because the H-reflex examinations were negative. Multiple daily chiropractic notes were reviewed. By my count the claimant underwent about 52 visits of chiropractic care from 9/17/02 through 12/18/02. The claimant underwent epidural steroid injections in January, February and March 2003. The claimant was reportedly scheduled for a laminectomy surgery; however, the claimant denied wanted to go through this surgery and, therefore, he was assessed to be at MMI in April 2003. The claimant did see a designated doctor in November 2002 who felt the claimant was not at MMI because he was reportedly pending a surgery which of course the claimant did not end up participating in. The claimant was also seeing ___ for epidural steroid injections and the claimant was also seeing ___ for orthopedic evaluation. It appears the claimant may have undergone some facet neurectomies sometime from March through June 2003. I found it interesting that ___ designated doctor exam of 4/22/03 revealed the claimant to have significant symptom magnification.

Requested Service(s)

Office visits with manipulation, neuromuscular re-education, electric stimulation, myofascial release, therapeutic exercises, mechanical traction and joint mobilization rendered from 12/20/02 through 2/11/03.

Decision

I agree with the insurance carrier and find that the services in dispute were not medically necessary except for the services rendered on 1/15/03, 1/17/03, 1/21/03, 2/6/03 and 2/11/03. It is my opinion that on these dates of service the only treatment that would be considered medically necessary would have been the 97112 code and only 2 units of the 97110 code.

Rationale/Basis for Decision

The remaining services rendered on these dates of service were mechanical traction, chiropractic manipulation, joint mobilization, and myofascial release, and these would be considered passive in nature

and not supported as reasonable or necessary as part of a typical post epidural steroid injection treatment protocol. The only reason the services of 1/15/03, 1/17/03, 1/21/03, 2/6/03 and 2/11/03 would be considered medically necessary would be that these occurred as part of a post epidural steroid injection physical therapy program. I will certainly agree with the carrier that the chiropractic services have been extensive in that the claimant has undergone 52 visits of chiropractic care prior to the epidural steroid injections. In fact, the claimant actually underwent about 56 visits prior to the first epidural steroid injection. This would be considered extremely excessive, especially without documented evidence of improvement. At any rate, the claimant is entitled in my opinion to a few physical therapy visits following epidural steroid injections. Since these epidural steroid injections were obviously approved and performed then a short course of physical therapy would be considered reasonable and customary to follow each epidural steroid injection for up to 2 weeks maximum following each injection. In this particular instance the claimant underwent his first epidural steroid injection on 1/8/03. It is my understanding that the services rendered on 1/10/03 and 1/13/03 were considered to be not in dispute and these were probably reimbursed to the treating physician. It was obvious from the chiropractic documentation that the claimant did not improve; however, this would seem make him a candidate for reasonable physical therapy. The 1/21/03 visit came at about 2 weeks following the epidural steroid injection and it was obvious from the chiropractic documentation that the claimant had not experienced a significant improvement whatsoever and any and all services rendered besides the ones rendered on 1/15/03, 1/17/03 and 1/21/03 would not be considered reasonable or medically necessary. Again, it is my understanding that the 1/10/03 and 1/13/03 visits were paid and these would also be considered reasonable and customary. Within these visits, however, the claimant received passive modality treatment to include mechanical traction, manipulation, office visit, and neuromuscular re-education. The claimant also received therapeutic activities for what was billed as 97110 for 4 units; however, it was apparent from the documentation that some of this treatment was aimed at the neck and shoulder, and therefore only 2 units would be considered reasonable and medically necessary. It is my opinion that manipulation was no longer indicated in that the claimant had undergone nearly 60 chiropractic manipulations by this date and further manipulation is not indicated and the highly evidence based Official Disability Guidelines recommend no more than anywhere from 6-18 visits for treatment of lumbar radicular syndromes. In fact, it is well documented in the medical literature that chiropractic manipulation in radicular type syndromes is not effective usually after 4-6 weeks especially if no improvement is noted. As far as the 2/6/03 and 2/11/03 dates of service, the 2/11/03 date of service is the last disputed date of service that I am supposed to address in this particular instance. It is my opinion that for the same reasons listed above, being that this was part of a post epidural steroid injection physical therapy program, that the services rendered on 2/6/03 and 2/11/03 would generally be considered reasonable and necessary. Please take note, however, that an office visit manipulation would not be considered reasonable or medically necessary as billed at 99213 on 2/6/03 and 2/11/03. Also documented on these dates of service was neuromuscular re-education at 97112 which would have been considered appropriate in that this was an active program. The 97265 code was used on 2/6/03 and 2/11/03 and this would be considered joint manipulation and not indicated especially since it appeared to be directed at the shoulder. The claimant's shoulder did not appear to be an ongoing problem in the documentation and joint manipulation this far from the date of injury for the shoulder would not be considered medically necessary or supported by the available documentation. The 97250 code was used for myofascial release and this modality is a passive treatment and the claimant had already undergone multiple visits of myofascial release and this is passive and not reasonable or customary as part of a post epidural steroid injection program. Again, it is my opinion that only 2 units of the 97110 code would have been considered medically necessary in that at least half of the 97110 code which is billed at 4 units was directed for the neck and shoulder. Two units, which would be 30 minutes, would have been sufficient to address any low back dysfunction and strengthening. It should also be noted that the purpose of an epidural steroid injection is to decrease pain and inflammation such that the claimant can be transitioned into more of an **active** care program.

This would diminish the need for passive treatment of any kind. It should also be noted that the maximum point of effect following an epidural steroid injection from the corticosteroid is 48-72 hours after the injection at which point 80% of recipients would feel the effects of the injection. This effect diminishes to some degree over time to 20% after 2 weeks following the injection. Therefore, it is imperative to participate in an active care program while the effects of the steroid are taking place. This would make the need for active care only to be reasonable and customary following an injection of this type.