

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 January 12, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. 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.

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 unattended electric stimulation, massage therapy, ultrasound therapy and therapeutic exercises were 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 11/05/03 through 11/10/03 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 16<sup>th</sup> day of March 2004.

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

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

**Date:** March 11, 2004

**MDR Tracking #:** M5-04-1315-01

**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**

It appears the claimant and a coworker were lifting and moving some scaffolding when the claimant felt a sudden pop and sharp pain in his low back. It was estimated that the scaffolding weighed well over 100 pounds. Even though the claimant experienced immediate pain, he continued to work but did inform a supervisor about the injury. The claimant continued to work with pain thinking that the pain would go away; however, as of 2/10/03 he was about 4 hours into his shift and began to experience sharp pains in the lumbar spine. The claimant did continue to work until 4:00 p.m. which was the end of his shift. He was beginning to experience moderate pain in his legs which he described as severe and cramping. The claimant continued to try to work; however, the intensity of the pain increased. As of 2/10/03 the claimant was complaining of pain in the left leg; however, as of 2/11/03 he was having more pain in the right leg. The claimant presented for chiropractic care on 2/11/03 under the direction of \_\_\_. The claimant underwent a trial of conservative chiropractic care; however, because he experienced no relief he was referred to \_\_\_. \_\_\_ felt the claimant needed surgery due to his overall clinical presentation as well as due to the findings of the MRI. The MRI report was provided for review and this was reviewed. The claimant appeared to have a significant amount of disc pathology in the lumbar spine with the worst areas being the T11/12 area as well as the T12/L1 level. The claimant ended up undergoing surgery with \_\_\_ on 8/6/03 and did not begin any type of post operative physical therapy until approximately 10/7/03 at which time he presented to \_\_\_ for post operative care. It was interesting to note that although the claimant continued to have significant pain and physical findings according to \_\_\_, \_\_\_ felt the claimant was doing fine. Due to ongoing problems, a repeat MRI was performed and upon my review of the repeat MRI of 1/7/04 there were really no changes at all compared to the pre-surgical MRI which was done on 3/11/03. In fact, the claimant saw \_\_\_ for designated doctor purposes on 1/29/04 and \_\_\_ actually stated that he was disturbed by the ongoing neurological compression which was occurring at the T11/12 and T12/L1 levels. In fact, \_\_\_ felt that a CT/myelogram was needed and felt that surgery would likely be needed. \_\_\_, on the other hand, felt that no surgery was needed and the claimant was fine. To complicate matters even further, the claimant saw \_\_\_ for RME purposes on 10/29/03 and it was felt further treatment beyond a home based exercise program was not needed. There was no evidence of neurological complications in the exam. \_\_\_ was under the mistaken impression that the claimant had been undergoing persistent chiropractic care, when indeed the claimant had only undergone about 2-3 weeks of post operative chiropractic care as of 10/29/03. \_\_\_ further felt that the claimant's current complaints as they pertained to the upper lumbar spine were related to the effects of the injury, whereas the lower lumbar spine complaints were related to the prior laminotomy procedures which were done back in 1997 or 1998. Multiple chiropractic follow up notes were reviewed and the daily chiropractic notes from the beginning of treatment through early 2004 were reviewed. The operative note of 8/6/03 was also reviewed.

**Requested Service(s)**

The medical necessity of the outpatient services including unattended electric stimulation, massage therapy, ultrasound therapy, and therapeutic exercises for dates of service of 11/5/03, 11/7/03, and 11/10/03.

**Decision**

I disagree with the insurance carrier and find that the services in dispute were medically necessary.

**Rationale/Basis for Decision**

The dates of service only include the 13<sup>th</sup>, 14<sup>th</sup> and 15<sup>th</sup> visits within the post operative setting. The claimant was not released to begin any type of post operative physical therapy until approximately 10/7/03 and I believe that given the type of surgery which was performed, as well as the fact the claimant did not begin post operative physical therapy until 10/7/03 that the services in dispute were well within the recommendations of the highly evidence based Official Disability Guidelines for treatment in the post operative setting. It should also be noted that the claimant's range of motion from 10/7/03 through 10/31/03 improved, even though his subjective status remained the same. The improvements in lumbar range of motion would actually be considered significant considering the fact that the claimant's lumbar MRI findings did not change as a result of the surgery. The note from \_\_\_ also stated that it is Medicare policy that indicates that the standard treatment for the 97110 code is up to 18 sessions within a 6 week period. It should be noted that the dates of services only encompass the 13<sup>th</sup> through 15<sup>th</sup> visits and the claimant was not cleared for post operative rehabilitation until 10/7/03. I believe it was also \_\_\_ impression that the claimant had undergone voluminous amounts of chiropractic treatment when indeed the claimant only underwent about 6 weeks of chiropractic treatment in the beginning stages of treatment and chiropractic treatment did not resume until 10/7/03. In fact, by the time the claimant saw \_\_\_ for his RME, the claimant had only been undergoing about 2-3 weeks of physical therapy in the post operative setting which was obviously not considered excessive or unreasonable. \_\_\_ further stated that he did "not see that there was a chronic need for ongoing chiropractic treatment for this spinal injury". It should be noted that the claimant was not in a chronic phase at this time because he was only 2-3 weeks into the post operative physical therapy portion of his treatment plan. It should also be noted that even though \_\_\_ felt the claimant was fine, it was obvious from \_\_\_ that the claimant was not fine and needed further evaluation. \_\_\_ also kept recommending further physical therapy beyond the disputed dates of service. At any rate, it is my strong opinion that the services in dispute would be considered medically necessary and were well within the recommendations of the highly evidence based Official Disability Guidelines for management of this particular condition in the post operative setting. Lack of significant neurological findings would not be a sufficient reason to deny treatment in the post operative setting in that a strong post surgical rehabilitation program would obviously be needed despite what the clinical findings were showing. In retrospect, the physical therapy in the post operative setting was not particularly effective; however, this would not mean that the services were not reasonable or medically necessary at the time they were rendered.