

THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER: 453-04-6008.M5

MDR Tracking Number: M5-04-1566-01

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 March 13, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits with manipulation, therapeutic exercises, neuromuscular reeducation, massage therapy, mechanical traction, and unattended electric stimulation were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 05-14-02 to 09-18-02 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 27th day of April 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

April 20, 2004

MDR Tracking Number: M5-04-1566-01
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

Available information suggests that this patient reports experiencing a low back injury that occurred while at work when bending over to tape a box on ___. She appears to begin seeing a chiropractor, ___, the same day and is diagnosed with lumbosacral plexus disorder, lumbar subluxation, sacroiliac sprain/strain, and muscle spasm. X-rays, passive therapy and chiropractic adjustments are performed 3-5x per week for several months. MRI is performed 01/07/98 suggesting only small left paracentral disc protrusion at L4/5 level. No evidence of disc herniation, stenosis or foraminal narrowing is noted. Lumbar myelogram is recommended if symptoms persist with conservative care. The patient is placed at MMI on 07/21/98 and is given a 9% WP impairment rating by designated doctor, ___. The patient apparently experiences a flare-up and presents with additional pain again to ___ on 10/31/00. This time, the treating doctor reports a "heavy fragmented disc with neurological compression" without new trauma. No additional imaging or other objective confirmation of this finding is provided for review. The patient presents again to ___ on 01/15/02, this time apparently due to pain from "a rather large herniated disc" that remains undocumented from objective findings. Adjustments and passive modalities are continued approximately 12 times through 2002 including the eight sessions in dispute from 05/14/02 through 09/18/02. Chiropractic notes continue to reference conditions related to large herniated disc or fragmented disc at L5. No repeat imaging or recommended lumbar myelogram appears to be performed. No specific causal exacerbation or reinjury is reported.

REQUESTED SERVICE (S)

Determine medical necessity for office visits w/manipulation, therapeutic exercises, neuromuscular reeducation, massage therapy, mechanical traction, and unattended electric stimulation for period in dispute 05/14/02 through 09/18/02.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Medical necessity for these ongoing treatments and services (05/14/02 through 09/18/02) **are not** supported by available documentation. Ongoing therapeutic modalities of this nature suggest little potential for further restoration of function or resolution of symptoms at several years post injury. With doctor's notes suggesting conditions inconsistent with objective evidence, medical necessity for continued services at these levels remains **unsupported**. Though chiropractic billing suggests 97112 and 97110 active therapies are provided, chiropractic notes on these dates do not document these services as being performed.

1. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.
2. Hurwitz EL, et al. The effectiveness of physical modalities among patients with low back pain randomized to chiropractic care: Findings from the UCLA Low Back Pain Study. *J Manipulative Physiol Ther* 2002; 25(1):10-20.
3. Bigos S., et. al., AHCP, Clinical Practice Guideline, Publication No. 95-0643, Public Health Service, December 1994.
4. Harris GR, Susman JL: "Managing musculoskeletal complaints with rehabilitation therapy" Journal of Family Practice, Dec 2002.
5. Morton JE. Manipulation in the treatment of acute low back pain. *J Man Manip Ther* 1999; 7(4): 182-189.
6. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Mercy Center Consensus Conference, Aspen Publishers, 1993.
7. Philadelphia Panel Evidence-Based Clinical Practice Guidelines on Selected Rehabilitation Physical Therapy, Volume 81, Number 10, October 2001.

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 medical/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 of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. 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 individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.