

MDR Tracking Number: M5-04-2119-01

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 12, 2004.

Based on correspondence received from the requestor, First Rio Valley Medical, P.A., dated, 08-11-04, date of service 11-13-03 for CPT code 99080-73 has been withdrawn.

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 office visits from 10-29-03 through 12-08-03 **were found** to be medically necessary. The therapeutic exercises and massage therapy from 10-29-03 through 12-08-03 **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 10-29-03 through 12-08-03 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 18th day of August 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

May 19, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

Re: Medical Dispute Resolution
MDR #: M5-04-2119-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's.
Letter of medical necessity 04/21/04.
Initial evaluation and clinical documentation 05/19/03 thru 12/10/03.
MRI 06/20/03 & 07/27/03

Clinical History:

The medical records provided for review indicated that the claimant was 47 years old at the time of the reported injury/accident (___). There is no record of emergency or exigent medical services for the patient's injury. In fact, there is no record of medical

service prior to 5/19/03 at which time the patient submitted a TWCC-53 change of treating doctor form. She sought chiropractic services on 05/19/03. The chiropractor evaluated the patient and assessed the following diagnoses: displacement of lumbar intervertebral without myelopathy, neck sprain, lumbar sprain, right shoulder sprain/strain. He proposed a treatment plan including physical medical modalities and rehabilitation measures to the lumbar and cervical spine levels 3 days a week for 6 weeks. He referred the patient to a pain management physician for medical consultation services.

Chiropractic services were provided throughout May and June of 2003. The treating doctor obtained a lumbar spine and cervical spine MRI on 06/20/03. The lumbar spine MRI disclosed early degenerative disc disease at L5-S1 and a 1-mm focal protrusion with no evidence of nerve root compression. The cervical spine MRI disclosed early degenerative disc disease at C5-C6 with protrusion at that level, but no evidence of acute findings. An MRI of the right shoulder was later obtained and interpreted as normal. These records indicate the patient received advanced invasive pain management services with fair results. She was determined to have reached maximum medical improvement on 12/31/03.

Disputed Services:

Therapeutic exercises, massage therapy and office visits during the period of 10/29/03 through 12/08/03.

Decision:

The reviewer partially agrees with the determination of the insurance carrier. The therapeutic exercises and massage therapy from 10/29/03 through 12/08/03 were not medically necessary. The office visits during the period in question were medically necessary in this case.

Rationale:

1. Regarding clinic-based therapeutic exercise and massage therapy services for the period in question for a neurologically uncomplicated low back pain condition 5 months post injury: these services are not reasonable, necessary, or appropriate. These services are not consistent with the Texas Worker's Compensation Commission Guidelines or current peer-reviewed medical literature regarding standard of care for management and treatment of acute low back pain.

This position is upheld by: The Official Disability Guidelines Publication of Work Loss Data Institute, 9th Edition, 2004. Regarding chiropractic services for the diagnosis of 722.1, I refer you to page 142 and 143, "Chiropractic Guidelines: The patient selected based on previous chiropractic success-trial of 6 visits over 2-3 weeks, evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity and gradually fade the patient into active self-directed care." With regard to the diagnosis of 847.0, I refer you to page 212 of the same document, "Chiropractic Guidelines (if not contraindicated by risk of stroke): Mild (grade 1) up to 7-10 visits over 2-3 weeks, moderate (grade 2) trial of 7-10 visits over 2-3 weeks, moderate (grade 2) with evidence of objective functional improvement total of up to 20 vitis over 6-8 weeks avoid chronicity."

The disposition is also upheld by venerable documents including the AHCTR Guidelines, The Texas Worker's Comp Commission Spine Treatment Guidelines, and chiropractic professions own Mercy Center Conference Guidelines.

2. Regarding the evaluation/management services for the same period of time: these services were reasonable and medically necessary for the chiropractor to fulfill his roles and responsibilities as the treating doctor. This position is upheld by the Texas Worker's Comp Commissions Spine Treatment Guidelines and the Commission's training modules for providers seeking ADL status.

Sincerely,