

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 23, 04.

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 aqua therapy (97113) from 06-03-03 to 06-18-03 **was found** to be medically necessary. The therapeutic activities (97530), joint mobilization (97265), electrical muscle stimulation attended (97032), unusual travel (99082), heat/cold pack (97010), manual traction (97122), application of modality (97022), EMS unattended (97014), office visit (99212/99211), CMT (3-4 reg / 98941, 98940), and mechanical traction (97012) from 05-30-03 to 09-10-03 also, the aqua therapy (97113) after 06-18-03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the services listed above.

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 06-03-03 through 06-18-03 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 30th day of June 2004.

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

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 27, 2004

MDR Tracking #: M5-04-2282-01
IRO Certificate #: 5242

AMENDED DECISION

___ 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

The claimant allegedly received injury to the low back region while performing occupational duties on ___. The said injury resultant of an apparent attempt to re-stock a marine battery (weighing approximately 50lbs), reportedly as slightly bent at knees while pulling the battery towards her (noted as using arm strength), evidently upon doing so, immediately heard a "pop." Although not experiencing immediate pain, it is recorded that a little bit of pain was experienced a few minutes later, which resulted in increased pain as the shift continued, due to the nature of occupational duties. The claimant is noted to have reported the alleged injury approximately one day later, due to the increased symptomatology.

Initial care, was reportedly administered at the emergency room (ER) in ___, approximately 3 days after the injury. X-rays were discussed as unremarkable, anti-inflammatory and pain medications were prescribed and claimant was instructed to seek treatment with a work comp doctor.

The claimant had only an initial exam with ___ in ___, before changing to ___, who apparently began chiropractic conservative care on or about February or March 2003.

Due to continued symptomatology, aquatic therapy, manipulations and a TENS unit was provided for self-administered pain relief.

The claimant referred to ___ for medication prescription and recommendations for pain management were addressed, as well as continued physiatric care maintenance (approximately every 2 months) by ___ for contributory pre-existing anxiety/depressive condition.

MRI findings, per report dated 4/12/03 confirmed a 3mm posterior disc herniation at L5-S1 and 2mm symmetric annular disc bulges and decreased widths by 10-15% at L3-L4 and L4-L5, with straightening of the usual or expected lordosis, which may reflect muscular pain or spasms.

NCV/EMG findings, per report dated 5/23/03 and denoted EMG dated 6/06/03, stated bilateral lower extremity TIBIAL H reflexes delayed, suggested reflex evidence lumbosacral radiculopathy at L5-S1, especially right S1, otherwise no abnormalities were reported.

The claimant is recorded to have stated that the continued physical therapy has made her condition worse, in addition to the disruption of sleep, sexual activity, and normal daily activities. She actually consulted with her physician regarding re-admittance for psychiatric care, denoted as due to the amount of added stress from the lack of improvement and progress, causing depression, anxiety, and discouragement resultant of the continued pain and radiculopathy.

Per final document by ___ dated 5/04/04, the claimant received pain management, aquatic therapy, and lumbar epidural steroid injection (ESI) were scheduled. Additionally, the claimant had returned to work (RTW), although a documented exacerbation condition was experienced.

Requested Service(s)

Please review and address the medical necessity of the outpatient services to include; therapeutic activities (97530), joint mobilization (97265), aquatic therapy (97113), unusual travel (99082), electrical stim attended (97032), heat/cold pack therapy (97010), manual traction (97122), application of modality (97022), electric muscle stimulation unattended (97014), office visit (99212/99211), CMT(3-4 reg) (98940/98941), mechanical traction (97012) for dates of service (DOS) from 5/30/03 thru 9/10/03 for the above mentioned claimant.

Decision

I disagree with the insurance company and find that a 2-week trial period of aqua therapy (97113) was medically necessary for DOS from 6/03/03 to 6/18/03. However, in the absence of documented improvement of lasting quality, this should have been discontinued.

I agree with the insurance company and find that; therapeutic activities (97530), joint mobilization (97265), electrical muscle stimulation attended (97032), unusual travel (99082), heat/cold pack (97010), manual traction (97122), application of modality (97022), EMS unattended (97014), office visit (99212/99211), CMT (3-4 reg / 98941), mechanical traction (97012) from 5/30/03 to 9/10/03 were not medically necessary with the exception of the aforementioned aqua therapy.

Rationale/Basis for Decision

Any guidelines that are quoted concerning necessity for treatment will require that subjective and objective findings demonstrate an improving lasting quality to warrant a reasonable or necessary continuation of treatment. Whether or not MRI disc bulging is causing pain or even that an EMG study hinted at possible radiculopathy is not the issue for a guarantee that continued treatment / therapy is necessary when it does not demonstrate a gradual improving character. The very fact that the claimant was recommended for and finally received ESI's denotes that prior therapy had failed.

However, other factors also were taken into consideration before rendering this decision. It was quite evident from an extensive amount of documentation that this claimant not only had an excessive amount of conservative care treatment prior to 5/30/03 for the primary diagnosis, but was not responding to that care (i.e. per numerous prior reviews by CONSILIUMMD). It was also evident that suspect disc pathology would have been a logical conclusion, early on, based on mechanism of injury, subjective response, and apparent initial exam objective findings, with or without an MRI examination. Based on this, it would be assumed that the treating doctor was selecting treatment based on this possibility. Therefore, MRI findings would not have drastically changed the treatment protocol, in as much as verifying the fact that these herniated conditions exist.

The FCE dated 6/14/03, makes it all so evident that the claimant had not improved over the past 4+ months of treatment and if pain recordings at that time (7 or 8, although 5 was recorded on 6/14/03), are accurate then how could one expect that this FCE would be that informative due to effort hampered by pain.

The examination on 7/25/03, by ____ (referral doctor), denotes low back pain of a constant variety, relieved only by medication and lying still. No real improvements are demonstrated by either claimant or doctor on this exam and this does not sound like someone who is improving with care.

On 10/01/03, a physician summary report by ____ clearly states that the claimant had structured physical therapy and that this has only significantly aggravated her radicular symptoms and the medications have given no relief, thus far. This in no way infers, that the claimant made progress or was even making progress and definitely not toward a RTW status.

Also noted, was the lack of pertinent information in the treating doctor notes concerning the exact progress of this claimant. General terms such as range of motion (ROM) is improving, strength is increasing, muscle spasm are decreasing, do not objectively demonstrate that improvement is being made. In fact, the pain scale from 8 to 5 is not exact evidence of significant progress of lasting quality. Later reports record high pain levels and medication usage did not appear to change or be alleviated. Subjective radiculopathy complaints continued in spite of the abundance of treatment (i.e. 9/05/03-subjective complaints still sharp low back pain and legs hurt. Pain levels before treatment 7).

Frankly, I don't see that the claimant was progressing towards RTW and that treatment was benefiting the claimant. Obviously, the documentation does not support it.

In response to the treating doctor's position statement; while some of what was discussed I agree with, it however does include areas I disagree with. To state past psychological history (which was currently being treated at the time of injury), should not override disc herniations, is not truly accurate. One could say disc herniation without severity findings (i.e. neuro compromise, etc.), should not override solid psychological findings. I'm sure the treating doctor could agree that this could, in high medical probability, be adding to this claimant's continuing subjective responses to pain, and cannot be ruled out.

The report that the claimant RTW on 7/09/03 and apparently reported an exacerbation condition, again does not denote that progress from previous treatment was obtained, this after 5+ months of concentrated therapy including, apparently 6 weeks of aquatic therapy. Furthermore, after another 2 months of continued therapy the claimant was still not RTW and was finally scheduled for ESI trials, due to failure of conservative care to that point.

One other point for the treating doctor to consider is the fact that an 8-5 pain scale reduction is not a quantifiable objective finding, since it is subjectively induced and if it is in collaboration with medication usage, it is difficult to denote if true progress is noted from therapy alone, unless a minimal-no pain, for lasting periods of time were recorded including decreased medication usage. This should help to reinforce as to how I arrived at these final decisions.

NOTE: Obviously, I do not make these decisions lightly or at random, however, in this case the claimant had excessive prior conservative care before the DOS in question (5/30/03 - 9/10/03) and that trial period did not support continued treatment of this variety. Furthermore, the documentation covering these dates, in my opinion, do not provide overwhelming evidence that the treatment was medically necessary, per previous rationale.