

MDR Tracking Number: M5-04-2820-01

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 April 30, 2004.

Based on correspondence received from the requestor, ____, dated 07-09-04, the requestor is withdrawing date of service 05-14-03 from their dispute.

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 level II and II office visits, therapeutic exercise, joint mobilization, myofascial release, group therapy and special reports **were** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

This Findings and Decision is hereby issued this 12th day of July 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

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 04-30-03 through 06-13-03 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 12th day of July 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/pr

MEDICAL REVIEW OF TEXAS
[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:
MDR Tracking Number: M5-04-2820-01
Name of Patient:
Name of URA/Payer:
Name of Provider: (ER, Hospital, or Other Facility)
Name of Physician: (Treating or Requesting)

July 6, 2004

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 Texas Medical Foundation, 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

Medical Review of Texas (MRT) 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 MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing injuries to her low back, right knee, right ankle and right elbow sustained on ___ while at work. She apparently slipped on a piece of plastic and fell to the floor. She presented initially to Memorial SW Hospital ER and received x-rays and medications. The patient later presented to a Dr. S at Concentra and was found with a contusion of the back and right shoulder. The patient was apparently displeased with these services and changed treating doctors to Dr. G, a chiropractor on 03/30/03. The patient was also sent to a Dr. T for pain management. Additional medications and physical therapy was recommended. Chiropractor began multiple passive and active physical therapy procedures. An MRI of the left knee was performed showing only degenerative changes. Lumbar MRI was obtained suggesting disc bulge at L5/S1. The patient was sent for orthopedic evaluation by a Dr. B and found with chondromalacia patella and mild lumbar discopathy. Knee and lumbar injections were offered. The patient was seen for an IME with another orthopedist, Dr. V, on 07/14/03. No spinal neuropathy or knee instability was noted. Some Waddells' Tests were found positive for symptom magnification. His findings suggest that chiropractic therapy exceeding 6-8 weeks would be unreasonable and unnecessary. EMG/NCV studies performed 07/14/04 suggest right S1 radiculopathy. The patient is returned to Dr. B for recommended epidural steroid injections. The patient apparently continues with chiropractic therapy with limited benefit.

REQUESTED SERVICE(S)

Determine medical necessity for level II and III office visits, therapeutic exercise, joint mobilization, myofascial release, group therapy and special reports (99080) for period in dispute 04/30/03 through 06/13/03.

DECISION

Services approved for dates of service 04/30/03 through 06/13/03.

RATIONALE/BASIS FOR DECISION

Medical necessity for these initial treatments and services **are generally supported** by available documentation during this acute phase of care (6-8 weeks duration). Ongoing therapeutic modalities of this nature beyond 8 weeks duration suggest little potential for further restoration of function or resolution of symptoms given the chronic nature of the complaints. With available documentation suggesting pre-existing degenerative conditions, limited functional improvement and behavioral or psychosocial overlay, it would appear that these issues would need to be appropriately addressed before continuing beyond 8 weeks duration. Treatments and services provided within the disputed time period (04/30/03 thru 06/13/03) do appear to be within the timeframe for appropriate trial of conservative care.

Report from _____, to Arkansas Claims Management, 07/14/03.

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., AHCPR, 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.