

MDR Tracking Number: M5-04-4138-01

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 August 4, 2004.

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 mechanical traction, electrical stimulation, ultrasound therapy, therapeutic exercises rendered on 8/6/03 thru 9/10/03 were not found to be 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 Medical Review Division has determined that **medical necessity was the only issue** to be resolved. As the treatment mechanical traction, electrical stimulation, ultrasound therapy, therapeutic exercises were not found to be medically necessary, reimbursement for dates of service from 8/6/03 thru 9/10/03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

September 27, 2004

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

Re: Medical Dispute Resolution
MDR #: M5-04-4138-01
TWCC#:
Injured Employee:
DOI:
SS#:
IRO Certificate No.: 5055

Dear

___ 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 ___ 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

Information provided by Requestor:

- letter of medical necessity 08/02/04
- office notes & correspondence 05/28/03 – 08/27/03
- MRI's lumbar spine 05/28, 08/27 and 06/13/2003
- designated doctor exam 10/01/03
- case review 11/06/03

Information provided by Spine Surgeon:

- office notes & consultations 07/03/03 – 07/30/03

Clinical History:

The claimant was working when she was involved in an accident on ___. She suffered injuries to the lumbar spine. On 05/28/03, the worker presented to the offices of her treating doctor (chiropractor) and was diagnosed with a strain/sprain of the lumbar spine, sciatica, muscle spasm, and lumbar disc displacement without myelopathy. A trial of conservative chiropractic applications that included therapeutic exercise, manipulation, ultrasound therapy, electrical muscle stimulation therapy, mechanical traction, and home exercise were initiated.

MR Imaging performed over the lumbar spine on 06/13/03 revealed mild bony IVS stenosis of the right due to hyperimbrication of the posterior joint that effaces the right L4 nerve root. Remainder of the imaging study is unremarkable for any reported physical/osseus pathology. The evaluation (M.D.) on 07/03/03 revealed that the claimant was not a candidate for antiinflammatory medications, surgery, or injection series; recommendations were made for the ongoing treatment with the chiropractor. Designated doctor examination on 10/01//03 revealed that the claimant was at maximum medical improvement (MMI) with reference to her strain/sprain injury to the lumbosacral region that was resultant of the ___ work-related event.

Disputed Services:

Mechanical traction therapy, electrical stimulation, ultrasound therapy and therapeutic exercises during the period of 08/06/03 through 09/10/03.

Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above was not medically necessary in this case.

Rationale:

The sheer volume of services rendered on this claimant from 08/06/03 through 09/10/03 that are passive-based applications are inappropriate and not medically necessary in the management of this claimant's condition. The provider treated this claimant with over 35 sessions from 05/28/03 through 09/24/03. There is no rationale for the frequency/duration of care noted in the review of the enclosed medical records.

It is evident that the claimant could be appropriately classified within a strain/sprain therapeutic algorithm following her work-related fall on _____. MR imaging of the lumbar spine performed on 06/13/03 was unremarkable for pathology that would have warranted a change in therapeutic algorithm. In treating a claimant within a strain/sprain algorithm, one should limit the application of passive applications like manipulation, electrical muscle stimulation therapy, mechanical therapy, and ultrasound therapy in lieu of more active, patient-driven therapeutics.

The provider failed to implement a clear transition towards active therapeutics and manage a strain/sprain of the lumbar spine for approximately 4 months. Medical records do not, in any capacity, provide qualitative/quantitative medical data that would support the efficacy of the provider's implementation of continued passive chiropractic management of this claimant's condition from 08/06/03 through 09/10/03.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- Official Disability Guidelines, 9th Edition. *Strains and Sprains of Other and Unspecified Parts of the Back (3-digit ICD-9 847)*.
- *Overview of Implementation of Outcome Assessment Case Management In The Clinical Practice*. Washington State Chiropractic Association; 2001. 54p.
- Triano, J. J. et al. *Differences in Treatment History With Manipulation For Acute, Sub-Acute, Chronic, and Recurrent Spine Pain*. J Manipulative Physiol Ther. 1992 Jan;15(1):24-30.
- Trionovich, S. J. et al. *Structural Rehabilitation Of The Spine And Posture: Rationale For Treatment Beyond Resolution Of Symptoms*. J Manipulative Physiol Ther. 1999 Jan;21(1):37-50.
- *Unremitting Low Back Pain. North American Spine Society Phase III. Clinical Guidelines for Multidisciplinary Spine Care Specialists*. North American Spine Society. 2000. 96 p.

Sincerely,