

MDR Tracking Number: M5-05-0042-01

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 assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 8-31-04.

The Medical Review 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 office visits, therapeutic exercises, manual therapy, neuromuscular reeducation and electrical stimulation from 9-2-03 through 1-20-04 were not medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision and Order is hereby issued this 7<sup>th</sup> day of December 2004.

Donna Auby  
Medical Dispute Resolution Officer  
Medical Review Division

DA/da

Enclosure: IRO decision

November 24, 2004

#### **NOTICE OF INDEPENDENT REVIEW DECISION**

**RE: MDR Tracking #: M5-05-0042-01**  
**TWCC #:**  
**Injured Employee:**  
**Requestor:**  
**Respondent:**  
**----- Case #:**

----- has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ----- IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ----- for independent review in accordance with this Rule.

----- has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ----- external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ----- chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ----- for independent review. In addition, the ----- chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

### Clinical History

This case concerns a 25 year-old male who sustained a work related injury on ----- . The patient reported that while at work he injured his back while lifting lumber. The initial diagnoses for this patient included cervical radiculitis, thoracic sprain/strain and myofasciitis. Initial treatment for this patient's condition included physical therapy and an orthopedic consultation. A MRI of the thoracic spine performed on 5/30/03 revealed a 2-3mm disc herniation at the T6-7 level, anterior wedging of the vertebral bodies of T11 and T12, and multiple areas of partial desiccation of the disc material at T6-7, T10-11, and T11-12. Treatment for this patient's condition has included physical therapy consisting of passive modalities including cryotherapy, hot packs, electrical muscular stimulation, ultrasound, manual therapy, joint mobilization, and myofascial release.

### Requested Services

Office visits, therapeutic exercises, manual therapy, neuromuscular reeducation, and electrical stimulation from 9/2/03 through 1/20/04.

### Documents and/or information used by the reviewer to reach a decision:

#### *Documents Submitted by Requestor:*

1. Initial Medical Report 5/7/03
2. MRI report 5/30/03
3. Initial Comprehensive Evaluation Note 7/2/03
4. Follow Up Notes 8/7/03 – 8/28/03
5. Daily Progress Notes 9/2/03 – 1/20/04

#### *Documents Submitted by Respondent:*

1. Peer Review 12/19/03, 7/30/03

### Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

### Rationale/Basis for Decision

The ----- chiropractor reviewer noted that this case concerns a 25 year-old male who sustained a work related injury to his back on -----. The ----- chiropractor reviewer also noted that the treatment for this patient's condition has included therapeutic exercises, manual therapy, neuromuscular reeducation, and electrical stimulation. The ----- chiropractor reviewer indicated that neuromuscular reeducation is provided to improve balance, coordination, kinesthetic sense, posture, motor skill and proprioception, and may be used for neuromuscular system impairments such as poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, and hypo/hypertonicity (HGSA Medicare Medical Policy Bulletin, Physical Therapy Rehabilitation Services, original policy effective date 4/1/1993 (Y-1B).) The ----- chiropractor reviewer explained that this patient's diagnoses did not require neuromuscular reeducation. The ----- chiropractor reviewer noted that the documentation provided did not support the need for continued monitored therapy. The ----- chiropractor reviewer explained that services that did not require "hands-on care" or supervision by a health care provider are not considered medically necessary services. The ----- chiropractor reviewer also explained that continuation of an unchanging treatment plan, performance of activities that can be performed as a home exercise program and/or modalities that provide the same effects as those that can be self applied are not indicated (Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MNR, Leffers P, van Tulder M. Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.) The ----- chiropractor reviewer indicated that the treating doctor failed to adequately support the rationale for continued supervised therapeutic exercises at that point in this patient's care.

The ----- chiropractor reviewer explained that the documentation provided did not support the medical necessity of the level of Evaluation and Management (E/M) service on each and every visit, especially not during an established treatment plan. (CPT 2004: Physicians Current Procedural Terminology, Fourth Edition, Revised (American Medical Association, Chicago, IL 1999).) The ----- chiropractor reviewer indicated that both the diagnosis and documentation supported the manual therapy techniques initially and concurrently with the injections rendered in the summer of 2003. However, the ----- chiropractor reviewer explained that they were no longer needed more than two weeks after the final injection, which was given on 8/20/03. Therefore, the ----- chiropractor consultant concluded that the office visits, therapeutic exercises, manual therapy, neuromuscular reeducation, and electrical stimulation from 9/2/03 through 1/20/04 were not medically necessary to treat this patient's condition.

Sincerely,

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State Appeals Department