

**THIS DECISION HAS BEEN APPEALED. THE
FOLLOWING IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-3363.M5

MDR Tracking Number: M5-05-0153-01

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 9-9-04.

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 the office visits, electrical stimulation, traction, manual therapy, and exercises were not 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 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 1-27-04 through 3-3-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 3rd day of December 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

DZT/dzt

November 16, 2004

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

Re: Medical Dispute Resolution
MDR #: M5-05-0153-01
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 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 licensed in chiropractic 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:

- Request for reconsideration 06/23/04
- Office notes ___ – 07/23/04
- Physical therapy notes 12/12/03 – 08/13/04
- FCE 01/28/04 – 03/11/04
- Radiology report 12/30/03

Information provided by Respondent:

- Correspondence and case summary

Information provided by Pain Management Specialist:

- Office notes 02/27/04 – 07/30/04
- Procedure notes 03/16/04 – 07/20/04

Information provided by Pain Management Specialist:

- Office note 01/21/04
- Procedure note 02/06/04

Clinical History:

Patient is a 36-year-old female who on ___ experienced lower back pain following a work-related accident. After a brief office visit by the company doctor that consisted of a drug screen only, she presented herself to a doctor of chiropractic who commenced chiropractic care and physical therapy. She was also treated concurrently with medications and eventually received five separate injections.

Disputed Services:

Office visits, electrical stimulation, traction, manual therapy and exercises during the period of 01/27/04 thru 03/03/04.

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 were not medically necessary in this case.

Rationale:

In this case, there was no evidence to support the need for continued monitored therapy. Services that do not require “hands-on care” or supervision of a health care provider are not considered medically necessary services even if they were performed by a health care provider. 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. Any gains obtained in this time period would have likely been achieved through performance of a home program.

In fact, current medical literature states, “...there is no strong evidence for the effectiveness of supervised training as compared to home exercises.”¹

Therapeutic exercises (97110) may be performed in a clinic one-on-one, in a clinic in a group, at a gym or at home with the least costly of these options being a home program. A home exercise program is also preferable because the patient can perform them on a daily basis. On the most basic level, the provider has failed to establish why there was a continued need of therapeutic exercises services one-on-one for the duration of time in this case.

Insofar as the passive therapies were concerned, it is the position of the Texas Chiropractic Association² that it is beneficial to proceed to the rehabilitation phase (if warranted) as rapidly as possible, and to minimize dependency upon passive forms of treatment/care since studies have shown a clear relationship between prolonged restricted activity and the risk of failure in returning to pre-injury status. The TCA Guidelines also state that repeated use of acute care measures alone generally fosters chronicity, physician dependence and over-utilization and the repeated use of passive treatment/care tends to promote physician dependence and chronicity. Therefore, the medical necessity of continued unattended electrical stimulation (G0283), manual therapy techniques (97140), and mechanical traction (97012) nearly 8 weeks post-injury was not supported.

The medical records revealed that the doctor of chiropractic performed chiropractic manipulation on only two dates of service (12/29/03 and 12/30/03), and those particular dates are not in dispute here. According to the AHCPR³ guidelines, spinal manipulation

¹ Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, 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.

² Quality Assurance Guidelines, Texas Chiropractic Association.

³ Bigos S., Bowyer O., Braen G., et al. Acute Low Back Problems in Adults. Clinical Practice Guideline No. 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, U.S. Department of Health and Human Services. December, 1994.

was the only recommended treatment that could relieve symptoms, increase function and hasten recovery for adults suffering from acute low back pain. Based on those findings, it is difficult to understand why a doctor of chiropractic would essentially withhold this recommended treatment while performing a host of other non-recommended therapies in its stead. Since the medical records indicate that manipulation was not performed as a component of the office visits (99212) in dispute, and since the manipulation code modifier (-MP) was not appended to the office visit services, the medical necessity was not supported for performing this level of Evaluation and Management (E/M) service on each and every visit during an established treatment plan per CPT ⁴.

Furthermore, upon review of the treating doctor's position, he repeatedly gave as a basis for the protracted treatment time in this case that this patient had a positive MRI, specifically quoting the MRI report that stated "posterior disc bulge impinging the thecal sac at L3-4 as well as L2-3." However, upon careful review of the actual MRI report, it was contradictory. In the body of the report, the radiologist reported, "There are small anterior disc bulges at L2-3 and L3-4. There are no protrusional abnormalities nor evidence of neural compromise." [emphasis added] Then, in the impressions section, under entry #2, it was reported, "L2-3 and L3-4: Posterior disc bulge impinging the thecal sac only," which contracts the findings as described. As a result, the presence of positive findings on an MRI is equivocal, and absent any other documentation justifying prolonged care, the medical necessity of the treatment provided was not supported.

⁴ CPT 2004: Physician's Current Procedural Terminology, Fourth Edition, Revised. (American Medical Association, Chicago, IL 1999),