

# Ziroc

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May 12, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

M5-05-1572-01

IRO #:

5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed provider board certified and specialized in chiropractic care. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

## RECORDS REVIEWED

1. Table of Dispute Services, 2-4-04 through 8-26-04.
2. Explanation of Benefits, 5-5-04 through 8-26-04.
3. Query of Treatment and Services, 4-9-03 through 10-13-04.
4. Medical reports from M. Refaeian, M.D., 4-9-03 through 12-22-03.
5. Lumbar MRI, 5-6-03.
6. Reports from Eastside Rehabilitation and El Paso Physical Therapy, 5-29-03 through 10-14-03.
7. Electrodiagnostic report, 5-8-03.

8. Lumbar range of motion evaluations, 6-24-03, 7-16-03, 7-25-03, and 8-19-03.
9. TWCC-21s dated 9-11-03 and 2-16-04.
10. Medical reports from Luis Vasquez, M.D., 12-12-03 through 9-23-04.
11. Cervical MRI, 12-17-03.
12. Dictated medical reports from Mark Crawford, D.C., 1-13-04, 5-19-04, and 6-18-04.
13. Chiropractic SOAP notes and Patient Record Reports from Mark Crawford, D.C., 2-6-04 through 8-31-04.
14. Review of Records Reports from Mark Crawford, D.C., 1-16-04 through 7-30-04.
15. Designated Doctor Evaluation from Rodney Simonsen, M.D., 2-11-04.
16. Exercise Worksheets, 10-20-04 through 8-26-04.
17. Progress note from Eastside Medical Care Center, 2-20-04.
18. Dictated report from Gilbert Mayorga, M.D., 2-19-04.
19. Lumbar x-ray reports, 2-18-04, 2-27-04, 3-30-04, and 5-14-04.
20. Lumbar CT report, 2-23-04.
21. Operative report, 2-26-04.
22. PPE, 5-19-04 and 6-18-04.
23. Lumbar MRI, 6-30-04.
24. FCE, 7-28-04.
25. Medical report from Jose Villarreal, M.D., 8-5-04.
26. FCE, 9-13-04.
27. Chronic Pain Assessment, 9-27-04.

### **CLINICAL HISTORY**

According to the records provided, the patient reported the onset of low back pain while pushing a sweeper on 4-3-03. The claimant was evaluated by Dr. Refaeian on 4-9-03. SLR was negative. Sensation was diminished in the lateral thigh. Lumbar flexion was 60 degrees. Diagnosis was lumbar strain. The physician recommended TENS, modified duty, lumbar corset, and prescribed Motrin and Skelaxin. Re-evaluation dated 4-29-03 indicated the patient was complaining of low back pain and bilateral leg pain. SLR on the right was 40 degrees. Lumbar flexion was 40 degrees and lateral bending was 20 degrees bilaterally. Diagnoses included lumbar sprain and possible lumbar radiculopathy.

Lumbar MRI dated 5-6-03 denoted:

1. Mild broad-based disc bulge at L2-3.
2. Mild broad-based disc bulge and mild bilateral facet arthropathy at L3-4.
3. Mild broad-based disc bulge and mild to moderate bilateral facet arthropathy producing moderate right and mild left foraminal stenosis at L4-5.
4. Grade I spondylolisthesis of L5 relative to S1 producing severe bilateral foraminal stenosis.

Electrodiagnostic testing on 5-8-03 revealed no evidence of lower extremity radiculopathy. Re-evaluation with Dr. Refaeian dated 5-29-03 revealed ongoing low back pain rated 7/10. The patient was referred to Dr. Cho, orthopedic surgeon. The patient declined epidural steroid injections. The patient attended physical therapy at El Paso Physical Therapy Lower Valley between 6-24-03 and 10-24-03. Treatment included hotpack, TENS, range of motion exercises, stretching exercises, strengthening exercises, and treadmill. Aquatic therapy was also performed. On 8-19-03, left lateral flexion was 26 degrees; right lateral flexion 25 degrees, flexion 56 degrees, and extension 24 degrees.

Re- evaluation with Dr. Refaeian was performed on 9-18-03. The physician felt the patient reached maximum medical improvement. The patient was returned to full duty, and 0% impairment was assigned.

On 12-9-03, the patient reported ongoing back and leg pain to Dr. Refaeian. SLR was positive on the left at 60 degrees. Lumbar flexion was 40 degrees. Diagnosis was lumbar disc herniation and spinal stenosis. Dr. Refaeian again placed the patient on modified duty.

On 12-12-03, the patient was evaluated by Luis Vasquez, M.D. The claimant reported ongoing low back pain grade 6-7/10. SLR was positive on the left at 40 degrees. Diagnoses included spondylolisthesis and disk protrusion at L2-3, L3-4, and L4-5. He recommended a lumbar fusion.

Cervical MRI dated 12-17-03 denoted:

1. Congenital stenosis.
2. Broad-based disc herniation at C5-6 with severe central canal stenosis.
3. Disc herniation at C3-C4.
4. Central disc herniation with central canal stenosis at C4-C5.

The patient started chiropractic treatment under the auspices a Mark Crawford, D.C. on 1-13-04. The claimant reported constant back pain rated 8/10. He described his symptoms as sharp, stabbing, and spasms. At the time, the patient was taking Skelaxin and Ibuprofen. Lumbar flexion was 30 degrees, extension 0 degrees, left lateral flexion 20 degrees, and right lateral flexion 25 degrees. Chiropractic treatment included electrical stimulation, ultrasound, massage, and therapeutic exercise.

A Designated Doctor Evaluation was performed by Rodney Simonsen, M.D. on 2-11-04. Because the patient was scheduled for surgery, the patient was not found to be at maximum medical improvement. On 2-19-04, patient was referred to Gilbert Mayorga, M.D. The patient was prescribed Lortab, Xanax, and Celebrex.

Lumbar MRI dated 2-23-04 denoted:

1. Broad-based disc bulge at L2-3.
2. Minimal broad-based disc bulge at L3-4.
3. Mild broad-based disc bulge at L4-5.
4. Spondylolisthesis at L5-S1.

On 2-26-04, the patient underwent a posterior lumbar decompression at L4-5, L5-S1 bilaterally with facetectomy, posterolateral fusion, and L4-S1 instrumentation. On 3-9-04, the patient indicated he was doing remarkably well. On 4-6-04, the patient reported some low back discomfort and some left leg pain. The patient was using a cane and wearing a lumbar corset. The patient was referred for passive physical therapy. Post-operative rehabilitation was implemented on 3-23-04 under the auspices of Mark Crawford, DC. Post-operative physical therapy continued through 8-31-04 including massage, electrical stimulation, ultrasound, and 2-6 units of one-on-one therapeutic exercise. Lumbar x-ray dated 5-14-04 denoted levoscoliosis of the lumbar spine with rotatory component and post-operative changes.

Lumbar MRI dated 6-30-04 denoted:

1. Post-surgical changes.
2. Grade I spondylolisthesis.
3. Degenerative disc disease from L2-3 through L5-S1.
4. Small right-sided disk protrusion at L2-3.

5. Foraminal narrowing from L3-4 through L5-S1.

On 6-15-04, Dr. Vasquez indicated the patient was continuing to have back and leg pain with extremity weakness. The physician felt the patient may be a candidate for a dorsal column stimulator due to a poor response from surgery and post-operative rehabilitation. On 7-27-04, Dr. Vasquez again indicated the patient failed to improve with surgery and post-operative rehabilitation and is therefore a candidate for a dorsal column stimulator.

On 7-28-04, a functional capacity evaluation indicated the patient was functioning in the sedentary-light physical demand level and his cardiovascular conditioning was rated sedentary. Numerical pain scale ranged between 6/10 and 10/10. Oswestry was 80 percent.

On 8-5-04, the patient was evaluated by Jose Villarreal, M.D. The patient reported a numerical pain scale of 9/10. Symptoms were sharp and constant. Symptoms also traveled into his left lower extremity. His sleep and appetite were diminished. At the time, the patient was taking Celebrex, Methocarbamol, and Hydrocodone with acetaminophen. In other words, the patient was doing poorly. The physician recommended a dorsal column stimulator.

The claimant had an epidural steroid injection in September with only one day relief. A FCE on 9-13-04 indicated the patient was functioning in the sedentary-light physical demand level and his cardiovascular conditioning was rated as sedentary. The patient's symptoms and functional abilities remained the same and/or deteriorated in regards to medication intake, lumbar range of motion, overall physical demand level, cardiovascular conditioning, shoulder lifting, overhead lift, and NIOSH floor, knee, arm, high-near, and high far lift, push ability, and pull ability. Even his numerical pain scale deteriorated ranging between 8/10 and 10/10.

A behavioral assessment was performed on 9-27-04. The patient reported a numerical pain scale of 8/10. He was having difficulty with standing, sitting, walking, and lifting. There was strong evidence of depression and anxiety. In fact, the patient admitted to having some suicidal ideations. GAF was 40.

### **DISPUTED SERVICES**

Under dispute is the medical necessity of Items in dispute included 99213 OV, 99212 OV, 97035 Ultrasound, 97110 Therapeutic exercises, 99358 Prolonged Srvc., 97124 Massage, and G0283 Elec. Stim. between 4-13-04 and 8-26-04.

### **DECISION**

1. The Reviewer disagrees with the insurance carrier's decision regarding the **timeframe** of the post-operative rehabilitation performed between 4-13-04 and 8-26-04. 16 weeks of postoperative rehabilitation falls within guideline parameters; however, in-office treatment frequency and intensity should be gradually reduced beyond the initial eight weeks.

2. The Reviewer disagrees with the insurance carrier's decision regarding the billing of 99213 and 99212. Post-operative reassessments are imperative in the management of back pain. In the Reviewer's medical opinion, re-evaluations are essential to document

the patient's current functional abilities and make changes to the program based on the physical examination findings.

2. The Reviewer agrees with the insurance carrier's decision regarding the **intensity of one-on-one exercise** billed. In The Reviewers medical opinion, the chiropractic documentation supports 2-3 units of one-on-one based care between 4-13-04 and 6-13-04; however, the chiropractic documentation only supports one unit of one-on-one based care between 6-13-04 and 8-26-04.

3. In the Reviewer's medical opinion, the 97035, 97124, and G0283 modalities were reasonable and necessary between 4-13-04 and 6-13-04; however, there is a lack of medical necessity for ongoing passive procedures beyond 6-13-04.

4. Based on the documentation provided, the 99358 (prolonged evaluation and management service) was not reasonable or necessary at any point. In the Reviewer's medical opinion, the documentation does not support the medical necessity of a prolonged evaluation and management service. Review of records is included in the 99213 and 99212 evaluation and management codes.

#### **BASIS FOR THE DECISION**

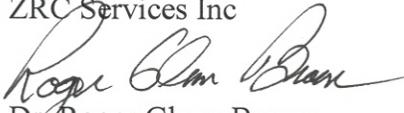
The patient underwent a lumbar fusion on 2-26-04 and post-operative rehabilitation was implemented on 4-13-04. In the Reviewer's medical opinion, post-operative rehabilitation following a lumbar fusion is certainly reasonable and necessary. A trial of post-operative rehabilitation is essential to secure symptomatic recovery, functional improvement, and return to work. The treatment timeframe performed between 4-13-04 and 8-26-04 falls within guideline parameters. The Official Disability Guidelines indicate the typical rehabilitation program following a lumbar fusion would include 8-16 weeks of therapy to include a balance between passive and active procedures. The patient should be prescribed a home exercise program; therefore, the patient should be independent with a home exercise program within 16 weeks.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding a copy of this finding by facsimile to the TWCC.

Sincerely,  
ZRC Services Inc



Dr. Roger Glenn Brown  
Chairman & CEO