

MDR Tracking #M5-05-1700-01

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 2-15-05.

In accordance with Rule 133.308 (e)(1), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The following date(s) of service are not timely and are not eligible for this review: 10-28-03 through 2-13-04.

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, therapeutic exercise, group therapeutic procedure, electrical stimulation, gait training therapy, manual therapy technique, ultrasound, neuromuscular reeducation, and DME-not specified from 2-17-04 through 4-27-04 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 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Finding and Decision is hereby issued this ___5th___ day of April, 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

Parker Healthcare Management Organization, Inc.
3719 North Belt Line Road, Irving, TX 75038
972.906.0603 972.906.0615 (fax)

Original Date: March 30, 2005

Amended Date: April 1, 2005

ATTN: Program Administrator
Texas Workers Compensation Commission
Medical Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100
Austin, TX 78744

Delivered by fax: 512.804.4868

IRO CASE NUMBER: M5-05-1700-01

RE: Independent review for ____
Amended Notice of Determination

The independent review for the patient named above has been completed. At the request of the TWCC, this determination has been amended. The only dates of service this determination will consider will be 2.17.04 – 4.27.04.

- Parker Healthcare Management received notification of independent review on 3.7.05.
- Faxed Notice of Assignment request for provider records on 3.10.05.
- The case was assigned to a reviewer on 3.23.05.
- The reviewer rendered a determination on 3.29.05.
- The Notice of Determination was originally sent on 3.30.05 and then amended on 4.1.05.

The findings of the independent review are as follows:

Summary of Clinical History

The patient was injured as a result of a work related incident on the date of _____. According to documentation provided, the patient was injured by lifting a wall that weighed an excess of 100 pounds. As a result of this, the patient began having lower back pain and radicular complaints. The patient has received a Discogram CT, orthopedic consultations, as well as various forms of rehabilitative and therapeutic intervention.

Questions for Review

Procedures including Office/outpatient visit, est, (99212), Office/outpatient visit, est, (99213), Therapeutic exercise (97110), Group therapeutic procedure (97150), Electrical Stimulation (97032), Gait training therapy (97116), Manual therapy technique (97140), Ultrasound (97035) and Neuromuscular reeducation (97112), DME not specified (E1399) are denied by the carrier based upon peer review. The dates in dispute are from 2.17.04 through 4.27.04.

Determination

The reviewer agrees with the denial of services rendered from 2.17.04 – 4.27.04. All medically appropriate care was rendered prior to this date range.

Clinical Rationale

The rationale for not supporting electrical stimulation (97032) is due to the fact that the patient's case is not in the acute stage of recovery during the time period in question but is rather in the remodeling phase. Typically, passive modalities (such as muscle stimulation) that are not specifically noted as making significant changes in the patient's condition serve no purpose in patient recovery during this phase of care. This is the situation in this patient's case. During this time period in question, there was no documentation of inflammation or other symptoms that would warrant passive / acute care. There was documentation of pain. The documentation of pain however did not specifically change or improve from the administration of electrical stimulation; therefore it is not supported as an appropriate form of care for this particular patient. At times passive modalities, such as, the one in question are reasonable to perform in conjunction with active care, regardless of the phase of care. However, it is usually performed with active care in order to reduce swelling or pain that might occur with rehabilitation. In this case, that

reasoning was not utilized nor was any other rationale for passive care. Therefore, electrical stimulation treatment is not reasonable.

Durable medical equipment is not clinically supported, as there is no provided rationale for such devices or therapies by the rendering doctor.

Active care listed such as therapeutic exercise, gait retraining, therapy technique, ultrasound, neuromuscular reeducation and group therapeutic procedures would have been necessary for a maximum of 12 visits, which was concluded prior to 2.17.04. Dr. Berliner reveals in his 4.29.04 report that the patient initially, or early in care, received four weeks of physical therapy and received some relief during that time period. According to Dr. Berliner, the care in question was the patient's second round of active care.

This in conjunction with the fact that the patient does have significant documentation of disc injury and ongoing subjective and objective findings would warrant the need for ongoing active care or another trial period of rehabilitation. However, during the time between February 2004 and April 2004, the patient's pain scale did not alter significantly. The pain drawings remained the same and the physical examination progress notes do not demonstrate clear objective increases in strength or range of motion with numbers that are generated by strict measurements using appropriate instrumentation. There was mention of improvement or changes and then percentages of improvement were listed. The problems is that there were no specific numbers in regards to degrees of range of motion or pounds in regards to strength that were listed to draw the conclusions of percentage of improvement. As a result a trial period of care at this point would be reasonable for up to 12 visits which would typically be administered in a six week time frame, according to the *Occupational Medicine Practice Guidelines* in the chapter on *Low Back Complaints*. In this situation it took a little longer to administer the recommended 12 visits.

After this trial it is recommended that surgical options be discussed if clinical and objective findings warrant the need for this discussion. It appears that a continuation of active care beyond the 12 visit mark or roughly the date of 2.17.04 is not necessary and did not serve as offering a symptom relieving or curative affect.

Clinical Criteria, Utilization Guidelines or other material referenced

Occupational Medicine Practice Guidelines, Second Edition.

The Medical Disability Advisor, Presley Reed MD

A Doctors Guide to Record Keeping, Utilization Management and Review, Gregg Fisher

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

The review was performed in accordance with Texas Insurance Code §21.58C and the rules of the Texas Workers Compensation Commission. In accordance with the act and the rules, the review is listed on the TWCC's list of approved providers, or has a temporary exemption. The review includes the determination and the clinical rationale to support the determination. Specific utilization review criteria or other treatment guidelines used in this review are referenced.

The reviewer signed a certification attesting that no known conflicts-of-interest exist between the reviewer and any of the providers or other parties associated with this case. The reviewer also attests that the review was performed without any bias for or against the patient, carrier, or other parties associated with this case.

Copies of this determination were faxed and mailed to the insurance carrier or URA, the provider, and the patient.

If our organization can be of any further assistance, please feel free to contact me.

Sincerely,

Meredith Thomas
Administrator

CC to be submitted by TWCC:

Houston Pain & Recovery
Attn: Juanita Lopez
Fax: 713.690.1508

Hammerman & Gainer
Attn: Melissa Rodriguez
Fax: 512.231.0210

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