

Ziroc

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June 3, 2005

TWCC Medical Dispute Resolution

Fax: (512) 804-4868

Patient:

TWCC #:

MDR Tracking #:

M5-05-1725-01

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. 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

Information from Requestor, Respondent, and Treating Doctor(s) including:

1. Medical Dispute Resolution Response.
2. Table of Dispute Services, 2-13-04 through 9-17-04.
3. EOBs, 2-6-04 through 9-17-04.
4. Chiropractic SOAP notes, 1-28-04 through 9-17-04.
5. Therapeutic Procedures Chart, 2-13-04 through 5-24-04.
6. Subsequent Medical Narrative Reports, 2-24-04, 4-6-04, and 6-15-04.
7. TWCC-73, 6-24-04.
8. Medical reports from Work Injury Recovery Center, dated 7-12-04, 8-6-04, and 8-13-04.
9. Peer Review by David Niekamp, D.C., 10-1-04.
10. Beck Inventory and McGill Pain Questionnaire, 8-31-04.
11. Lumbar MRI, 9-22-04.

12. Reconsideration letter (dates of service 6-15-04 through 9-17-04) from Cody Doyle, D.C., undated.

CLINICAL HISTORY

According to the documentation provided, the claimant fell after attempting to sit down while working as a waitress for the . The patient reported a low back injury.

On 1-27-04, the patient was evaluated by Cody Dole, D.C. The patient reported frequent lumbosacral pain rated 6/10 and intermittent numbness in the right leg rated 5/10. The claimant was taken off work. A passive and active based treatment approach was implemented on 1-27-04 and continued through 9-17-04. Treatment included manual therapy, electrical stimulation, biofreeze, moist heat/icepack application, and one-on-one guided exercise including therapeutic activities and therapeutic procedures.

According to the records, in-office passive modalities were implemented for more than eight months from 2-13-04 through 9-17-04. Additionally, one-on-one guided exercise was billed at an intensity of up to **\$200-\$400 per visit**.

A 7-12-04, after nearly six months of chiropractic treatment, a behavioral assessment was performed by Charles Hill, LPC. The patient reported ongoing low back pain. She indicated her legs were getting weaker. The patient was still not working. The claimant reported only temporary relief with moist heat. Physical therapy "made her pain worse." The claimant was taking Vicodin and admitted to taking too much medication. Pain behaviors included pacing, shifting, reporting constant pain, and leg numbness. The patient's numerical pain scale was 8/10. Again, symptoms were present "100 percent of the time." GAFF was 55. The therapist recommended individual counseling sessions.

On 8-6-04, the patient was evaluated by Ronald Davis, D.O. The patient reported low back pain and bilateral leg symptoms. Symptoms were provoked with walking, standing, sitting, and bending. Symptoms were constant and sharp. Numerical pain scale was 8/10. The patient reported she was receiving only 4-5 hours of sleep per night. He performed trigger point injections. Re-evaluation on 8-13-04 revealed ongoing complaints of pain and disability. The patient was taking 7-8 Hydrocodone pills per day. She was also taking up to 10 Soma per day. Back Inventory and McGill Pain Questionnaire revealed pain behaviors.

Lumbar MRI dated 9-22-04 was normal.

DISPUTED SERVICES

Under dispute is the medical necessity of therapeutic exercise (97110), therapeutic activities (97530), manual therapy technique (97140), electrical stimulation (97032), surface stimulation (64550), range of motion testing (95851), muscle testing (95831), prolonged physical services (99354), electrical stimulation (G0283), biofreeze (99070), office visits (99213 and 99214), and moist heat/icepack (97010) between the dates 2/13/04 thru 9/17/04.

DETERMINATION/DECISION

The Reviewer partially agrees with the determination of the insurance carrier in this case.

1. The chiropractic treatment performed between 1-27-04 and 3-19-04 was reasonable and necessary.
2. 2 units of therapeutic exercise from 2-13-04 through 3-19-04 reasonable and necessary; 5 units of the 7 units were reasonable and necessary.

3. All the chiropractic treatment and diagnostic testing (97110, 97530, 97140, 97032, 99354, G0283, 99070, 99213, 99214, 64550, 95851, and 95831) performed beyond 3-19-04 was neither reasonable nor necessary as it relates to the compensable injury.

BASIS FOR THE DECISION

In the Reviewer's medical opinion, the treatment timeframe between 1-27-04 and 3-19-04 was reasonable and necessary to treat the compensable injury. It is well established in the medical literature that the typical lumbar sprain/strain will require 6- 8 weeks of passive and active treatment interventions. Additionally, this treatment timeframe falls well within guideline parameters (Official Disability Guidelines, AHCPR Guidelines, ACOEM Guidelines, Mercy Guidelines and NASS Guidelines) for an uncomplicated lumbar sprain/strain.

In regards to one-on-one supervised rehab (97110 and 97530), the chiropractic documentation only supports two units of one-on-one therapeutic exercise/activities between 2-13-04 and 3-19-04 and does not support any beyond 3-19-04. The documentation clearly does not support the intensity (\$200-\$400 per visit) of one-on-one guided therapeutic exercise/activities billed. After a close review of the exercise flow-sheet, the Reviewer believes the exercise documented could have easily been performed within 30 minutes; therefore, 1 ½ hours of therapeutic exercise is excessive based on the program implemented. Additionally, the program was not adequately progressed to require one-on-one supervision. Simply performing the same exercise program over and over again does not require one-on-one supervision. There is no strong evidence for the effectiveness of supervised training as compared to an independent home program (Ostelo, Spine, 2003) once the exercise program has been established within the initial 8 weeks. Furthermore, there is some medical evidence indicating aerobic exercise independently is an effective treatment strategy for chronic pain and can actually be as effective as active physiotherapy and reconditioning on training devices (Mannion et al, Spine, 1999, Volvo Award Winner). The Reviewer is certainly not insinuating that no supervised treatment is reasonable; however, it is the Reviewer's belief that once a program has been established, independence with of home exercise program can be more cost-effective, quite motivational, and can be done on a daily basis.

In the Reviewer's medical opinion, the range of motion testing (95851) and muscle testing (95831) billed by the chiropractor was not reasonable or necessary. First, there are no well-controlled studies that support the use of computerized muscle testing over more cost-effective ways of measuring strength and endurance. Second, a well-trained physician can test baseline measurements and quantify objective improvement by more cost-effective measures. These can include dual inclinometer and goniometer measurements for range of motion, orthopedic testing, and endurance tests such as Kraus-Weber, Sorenson's, repetitive sit-up, and repetitive back extension testing. These tests have been found to be valid, reliable, safe, practical, and responsive measures of trunk strength and endurance. There is no indication that computerized range of motion testing and computerized muscle testing is any more useful than a good thorough physical examination. Range of motion testing and muscle testing is included in the evaluation code 99213 that was also billed by the chiropractor.

99213 and 99214 was reasonable and necessary through 3-19-04. Beyond this date, no E&M services were required for reasons listed below.

In the Reviewer's medical opinion, the documentation does not support any chiropractic treatment beyond 3-19-04 for multiple reasons.

First, the documentation fails to demonstrate adequate subjective improvement as a result of the treatment performed beyond 3-19-04. On 2-24-04, the patient reported frequent low back pain rated 6/10 and intermittent right leg numbness rated 5/10. Lasting subjective improvement

did not occur beyond this time frame. In fact, subjectively, the patient deteriorated. The behavioral assessment dated 7-12-04 clearly indicated “physical therapy made her pain worse.” The inter-tester documentation clearly demonstrates a numerical pain scale ranging between 7/10 and 9/10 beyond 3-19-04. The chiropractic documentation dated 6-15-04 demonstrates “severe” symptoms rated 8/10. Low back symptoms were constant and lower extremity symptoms were frequent. This clearly demonstrates subjective deterioration despite the protracted course of care.

Second, the treatment extended far beyond guideline parameters. The Mercy Guidelines and most accepted medical guidelines indicate the uncomplicated, untreated sprain/strain injury is expected to improve significantly within 6-8 weeks. With appropriate treatment we would expect a more expeditious recovery and a more complete recovery. In order to support treatment beyond guideline parameters, the documentation must indicate the treatment was efficacious with routine reevaluations demonstrating quantified and measurable improvement. This simply did not occur.

Third, the documentation fails to demonstrate adequate objective improvement as a result of the treatment provided. Tests and measurements form the objective core in the evaluation process for determining a successful treatment strategy. On 2-24-04, the chiropractic documentation demonstrates 7 provocative orthopedic tests, left SLR of 45°, right SLR of 30°, lumbar flexion of 15 pounds, extension 15 pounds, lateral flexion approximately 10 pounds, and rotation approximately 10 pounds. On 6-15-04, after an additional 4 months of chiropractic treatment, the documentation demonstrates 9 provocative orthopedic tests, left SLR of 18°, right SLR of 22°, lumbar flexion of 7 pounds, extension 11 pounds, lateral flexion approximately 7 pounds, and rotation approximately 8 pounds. Essentially, the patient’s functional status deteriorated in many regards despite the treatment.

In the Reviewer’s medical opinion, any improvement made was more related to the passage of time than to any supervised treatment. Additionally, there is absolutely no inter-tester documentation of objective improvement whatsoever. The other health-care providers who evaluated this patient indicated therapy was unsuccessful and/or “made her worse.”

Fourth, the most meaningful outcome measurement tool available is the rate of return to work. The Official Disability Guidelines indicate the typical “severe” lumbar sprain/strain injury will return to “heavy manual labor” within 35 days and “at-risk” patients will typically return to work within 79 days. Burdorf et al (The natural history of sickness absence due to low back pain and prognostic factors for return to work among occupational populations, 2002) reviewed 10 high-quality studies and found 91 percent of injured workers will return to work by three months. Mahmud et al (Journal on Occupational and Environmental Medicine, 2000) found that axial back pain in the workers’ compensation system were off work for an average of 17 days.

According to the documentation, this patient has been off work since the date of injury. This clearly indicates the treatment did not enhance the ability of the patient to return to work. In fact, the treatment may have contributed to dependency upon in-office treatment. Rule 134.600 indicates over-utilization of medical care can both endanger that health of the injured worker and inflate the health-care system costs. Unnecessary treatment may place the injured worker at medical risk for a disability mindset. The longer an injured worker is off work with back pain, the lower the chance he/she will return to work (McGill et al, Journal of Occupational Medicine, 1996). Additionally, Krause et al (Journal of Industrial Medicine, 1999) confirmed this. Returning to work is essential in the management of low back pain. In the Reviewer’s medical opinion, the medical management seemed unmindful of the devastating impact of prolonged disability.

The patient sustained a simple sprain/strain; therefore, there is absolutely no medical reason for this patient to remain off work for greater than 2-4 weeks. The documentation indicates the lumbar spine MRI was “negative.” In other words, returning to work could in no way further damage any structural anatomy because of the fact the original work-related injury

did not result in any architectural disturbance. In the Reviewer's medical opinion, the patient was at no risk for further injury with return to work.

Fifth, the documentation clearly indicates the chiropractic/physical therapy treatment has not reduced the dependency on the health-care system. In fact, it appears the patient's dependency upon the health-care system has actually grown. Despite 7 months of chiropractic treatment and up to 1-2 hours of exercise per visit, the patient was taking 7-8 hydrocodone per day and up to 10 Soma per day. Additionally, chronic pain management program and/or a Work Hardening Program were recommended due to a poor response with treatment. This clearly indicates strong dependency upon the medical system.

Sixth, the passive procedures implemented (manual therapy techniques, electrical stimulation, biofreeze, and moist heat/icepack application) beyond 3-19-04 cannot be supported. No consistent benefit has been shown with passive modalities/procedures on relevant outcomes such as pain, patient global assessment, and RTW for sub-acute or chronic low back pain > 8 weeks. At no point was surface neurostimulator application (64550) reasonable or necessary. This is a CPT code reserved for surgery/nervous system treatment and therefore falls outside the chiropractor's scope of practice. Additionally, there are two codes that suffice, G0283 and 97032.

In summary, all the chiropractic treatment performed beyond 3-17-04 was unreasonable and unnecessary. The documentation did not demonstrate adequate intra-tester improvement and certainly did not demonstrate adequate inter-tester improvement despite the protracted treatment plan. The treatment did not adequately relieve the effects of the injury, objectively promote recovery, reduce dependency upon the health-care system, or enhance the ability of the patient to return to work.

CERTIFICATION BY OFFICER

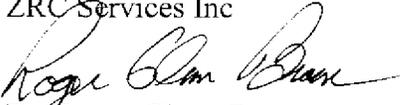
Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

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