

MDR Tracking #M5-05-1794-01

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 02-28-05.

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 ultrasound, manual therapy, neuromuscular re-education, therapeutic exercises and office visits 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 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 from 03-10-04 to 10-15-04 is denied and the Medical Review Division declines to issue an Order in this dispute.

This Findings and Decision is hereby issued this 19th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division
Enclosure: IRO decision

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive

Austin, Texas 78738

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

REVISED 5/16/05

TWCC Case Number:	
MDR Tracking Number:	M5-05-1794-01
Name of Patient:	_____
Name of URA/Payer:	Pain & Recovery Clinic
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic
Name of Physician: (Treating or Requesting)	Dean McMillan, MD

May 10, 2005

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Texas Workers Compensation Commission

CLINICAL HISTORY

This is a gentleman who reportedly sustained a lumbar myofascial strain type injury on or about _____. He was treated with medications, modified duty and physical therapy. One month later care transferred to another clinic and a physical therapy program that

included ultrasound, electrical stimulation, manual therapy and generalized conditioning was initiated. Imaging studies noted a number of degenerative processes and electrodiagnostic studies reported a verifiable radiculopathy. One month later, after implementing the active and passive modalities noted above, there was a reported increase in the pain complaints. An orthopedic assessment noted a surgical lesion and the procedure was carried out on June 11, 2004.

REQUESTED SERVICE(S)

Ultrasound (97035); Manual Therapy (97140); Neuromuscular Reeducation (97112); Therapeutic Exercise (97110); Office Visits for dates of service 3/10/04 through 10/15/04.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Prior to the date of surgery (June 11, 2004) this was a myofascial soft tissue low back strain in the face of significant and pre-existing degenerative changes. As noted in both the ACOEM and ODG Guidelines, a physical therapy protocol is warranted in treating the myofascial low back strain. Again, however, there needs to be documentation of improvement or some success with the treatment plan. That standard was not noted. Writing in Lumbar Disc Herniation (William & Wilkins 202) Nordin and Campello note that a trial of a mixture of active and passive modalities should be tried. However, if there is no significant improvement in the first 2 weeks, an alternative program should be implemented. Noting the dates of prior treatment, and that the protocol did not begin until one month after the date of injury there was no clear clinical indication for repeating the same methodologies when there was a prior failure to respond. The chiropractic progress notes indicate a "better than last time" check off box, but the physician progress notes indicates a "persistent low back pain" and that the claimant does not feel that he has any lasting or significant relief. This is contrary to the daily chiropractic progress notes. Continuing, Nordin and Campello note that post-operatively there is an indication for physical training. What needs to be tempered here is that this was an endoscopic procedure. There was no retraction of the paraspinal musculature. Therefore, the modalities addressing the muscular tissues (Ultrasound, Manual therapy and neuromuscular reeducation) would be considered unnecessary. After

the initial training session, the claimant could very easily complete the rehabilitation with a minimum of supervision, if any was needed at all. The therapist made no allowance in the treatment plan for the endoscopically treated disc lesion. As noted in Campbell's the post-operative rehabilitation on the endoscopically treated spine is different than the open procedure. This apparent boilerplate treatment plan was for the more significant open procedure when this did not occur. This assessment is based on the December 14, 2004 progress notes where the procedure described was a hemilaminectomy when an endoscopic laminotomy and discectomy was completed.