



Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

Retrospective Medical Necessity

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider () Injured Employee () Insurance Carrier	
Requestors Name and Address: Michael Margolies, D. C. 208 W. Spring Valley Rd. Richardson, TX 75081	MDR Tracking No.: M5-07-0123-01 Previous Tracking No.: M4-04-5076-01
	Claim No.:
	Injured Employee's Name:
Respondent's Name and Address: Texas Mutual Insurance Company, Box 54	Date of Injury:
	Employer's Name:
	Insurance Carrier's No.:

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The patient was only treated for a time frame of 12 weeks and such treatment is not unreasonable and should be paid for per the TWCC (sic) fee guidelines. If the attached claims and bills are not reprocessed and paid within the time frame of 21 days per the TECC rules this file and the outstanding charges will be forwarded over to Medical Dispute Resolution..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. CMS-1500's
3. EOB's

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Position Summary: "The service is dispute was unnecessary therefore this is a medial necessity dispute..."

Principle Documentation:

1. DWC-60/Table of Disputed Services/Position Summary
2. EOB's

PART IV: SUMMARY OF DISPUTE AND FINDINGS - Medical Necessity Services

Date(s) of Service	CPT Code(s) or Description	Medically Necessary?	Additional Amount Due (if any)
2-24-03 – 5-20-03	99090, 97750-PPE, E1300, J2000, 20550, 99213, 97265, 97250, 97122, 97110, A0100, E1399, E0745, A4630, 99273, 76856-WP, 76800-WP, 99214	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$0.00
	Total Due		\$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code and Division Rule 133.308 (relating to Medical Dispute Resolution by Independent Review Organization), Medical Dispute Resolution assigned an Independent Review Organization (IRO) to conduct a review of the medical necessity issues between the Requestor and Respondent.

The Division has reviewed the enclosed IRO decision and determined that the Requestor did not prevail on the disputed medical necessity issues. No reimbursement recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

Texas Labor Code 413.011(a-d) and 413.031
28 Texas Administrative Code Sec, 133.308 and 134.1

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. 413.031, the Division has determined that the Requestor is not entitled to reimbursement of the IRO fee and is not entitled to reimbursement for the services involved in this dispute.

Findings and Decision by:

01-31-07

Authorized Signature

Typed Name

Date of Findings and Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

TX DEPT OF INS DIV OF WC
AUSTIN, TX 78744-1609

CLAIMANT: ___
EMPLOYEE: ___
POLICY: M5-07-0123-01
CLIENT TRACKING NUMBER: M5-07-0123-01/5278

Amended 1/19/07:

Medical Review Institute of America (MRIOA) has been certified by the Texas Department of Insurance as an Independent Review Organization (IRO). The Texas Department of Insurance Division of Workers Compensation has assigned the above-mentioned case to MRIOA for independent review in accordance with DWC Rule 133 which provides for medical dispute resolution by an IRO.

MRIOA has performed an independent review of the proposed care 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. Itemization of this information will follow.

The independent review was performed by a peer of the treating provider for this patient. The reviewer in this case is on the DWC approved doctor list (ADL). The reviewing provider has no known conflicts of interest existing between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Records Received:

RECORDS FROM STATE:

- 1) 1 Page Notification of IRO Assignment dated 11/3/06.
- 2) 1 page letter dated 11/3/06 from Texas Department of Insurance, Division of Workers' Compensation addressed to Medical Review Institute of America.
- 3) 2 pages Medical Dispute Resolution Request/Response.
- 4) 9 pages Table of Disputed Services from 2/24/03 to 5/3/03, total of \$8,180.00.
- 5) 7 pages Explanation of Benefits from Texas Mutual Insurance Company.

RECORDS RECEIVED FROM THE REQUESTOR:

- 6) 1 page Medical Dispute Resolution Request/Response.
- 7) 9 pages Table of Disputed Services from 2/24/03 to 5/20/03, total of \$8,180.00.
- 8) 30 pages Explanation of Benefits from Texas Mutual Insurance Company from 2/24/03 to 5/19/03, total of 23 visits.
- 9) 1 page second page of report unsigned by Richard Lane, D.O.
- 10) 1 page letter dated 1/8/03 addressed to Texas Workers' Compensation Commission from Multicare Medical Group, signed by Deann R. Redman.
- 11) 1 page letter dated 6/13/03 from Texas Workers' Compensation Commission addressed to Rogers Booker & Trevino.
- 12) 5 pages Decision and Order from Texas Workers' Compensation Commission, Hearing Division.
- 13) 43 pages Daily Progress Notes for dates 2/21/03 to 6/9/03, total of 43 visits.
- 14) 7 pages Documentation of Procedure for dates 2/21/03 to 5/7/03.

- 15) 8 pages DME Prescription Forms dated 2/21/03 to 6/20/03.
- 16) 32 pages Initial Medical Evaluations from 2/21/03 to 8/28/03, total of 17 evaluations, from Multicare Medical Group, unsigned by Richard Lane, D.O.
- 17) 7 pages Physical Performance Evaluation dated 2/24/03.
- 18) 5 pages report dated 2/28/03 addressed to "To Whom It May Concern", unsigned.
- 19) 1 page Procedure Note Trigger Point Injections dated 3/19/03 from Multicare Medical Group, signed by Richard Lane, D.O.
- 20) 2 pages Consent for Trigger Point Injection Therapy, signed by Marvel Brownlee and dated 3/19/03.
- 21) 4 pages Ultrasound report dated 4/8/03 from The American Institute of Musculoskeletal Diagnostic Ultrasound, signed by Marvin Goldman, M.D. and Alex Kaliakin, D.C.
- 22) 2 pages NCV dated 4/7/03 from Neurotherapy Center of Dallas, Inc., signed by Jonathan E. Walker, M.D.
- 23) 7 pages Physical Performance Evaluation dated 2/24/03 from AmeriMed, unsigned. (Appears to be same as Multicare Medical Group).
- 24) 12 pages Physical Performance Evaluation dated 4/15/03, from Multicare Medical Group, unsigned.
- 25) 10 pages Physical Performance Evaluation dated 5/6/03 from AmeriMed, unsigned. (Appears to be same as Multicare Medical Group).
- 26) 2 pages MRI report dated 6/27/03 from North Dallas Diagnostic Center, signed by Randolph T. Leone, M.D.
- 27) 2 pages Request for Reconsideration dated 8/16/03 from Multicare Medical Group addressed to Texas Mutual Bill Review, unsigned by Kim Lookingbill, Account resolution.
- 28) 2 pages letter dated 1/21/04 addressed to Texas Workers' Compensation Commission from Texas Mutual Insurance Company

RECORDS FROM INSURANCE COMPANY (RESPONDENT):

- 29) 2 pages letter dated 11/30/06 addressed to Medical Review Institute of America from Texas Mutual Insurance Company.
- 30) 3 pages Electrodiagnostic Results dated 4/7/03 from Mobile EMG, Inc.
- 31) 2 pages Follow Up Examination dated 4/9/03 from Multicare Medical Group, unsigned by Richard Lane, D.O.
- 32) 1 page TWCC-69-Report of Medical Evaluation dated 8/13/03.
- 33) 2 pages Impairment Report dated 8/13/03 from Multicare Medical Group PA, rubber stamp signature of Michael Margolies, D.C.
- 34) 1 page TWCC-69) Report of Medical Evaluation dated 10/23/03.
- 35) 8 pages Report of Medical Evaluation and Impairment Rating dated 10/23/03 addressed to Texas Workers' Compensation Commission from Churchill Evaluation Centers

Summary of Treatment/Case History:

This is a retrospective utilization review of services provided to this injured worker from 2/24/03 to 5/20/03. All the records received were analyzed.

The records indicate the patient alleges an industrial injury on ___ while employed by _____ "pulling files and lifting boxes." The patient alleges she began to feel pain in her low back which intensified. She advised her supervisor by phone and sought care from a doctor (seen on 2/21/03) she obtained from the telephone book. The doctor placed her on temporary disability status which prevented her from returning to employment offered by _____. The patient was released from care on 6/4/03 and returned to the workforce on 6/9/03. Apparently the claim was disputed by the carrier and a hearing was held by the Hearing Division of the Texas Workers' Compensation Commission and the carrier was ordered to cover medical treatment and income benefits.

There is no documentation provided of the original patient intake forms. There is no copy of the original physical examination performed or measurable objective findings. The first documentation provided from the treating doctor of chiropractic is dated 2/21/03, which is a Daily Progress Note. It indicates the patient's complaint as back, neck and shoulder. The pain drawing has a circle across the low back, with no indication of neck or shoulder involvement. Objective findings has an "X" at L. Rom. and "L" indicating

spasm, swelling, L. Rom and tenderness. Under "Plan" there are "x's" at joint mobilization, massage and myofascial release. Under remarks there is an indication the patient was to be seen on Monday to quantify qualitative findings of decreased range of motion and decreased muscle strength. The form is signed by the patient. A form, Documentation of Procedure, indicates transportation was provided to the patient for treatment. Another form, DME Prescription Form indicated topical analgesic was provided as well as EMS rental with electrodes and battery. On the same day a Richard Lane, D.O. performed a medical examination and prepared a report referred to as "Initial Medical Evaluation." The patient presented with subjective complaint of low back pain, difficulty sleeping due to pain at night. Dr. Lane references range of motion being limited but the report does not indicate the degree of loss or how it was determined. He noted moderate muscle spasms with pain reproduced by bending, sitting, standing, straight leg raise and a positive Patrick's FABERE bilaterally. Dr. Lane diagnosed acute lumbar strain. He recommended physiotherapy at 4 to 8 weeks, deferred trigger point injections, referral to an orthopedic surgeon, EMG/NCS and MRI and a review in one week. Treatment was implemented with the patient receiving joint mobilization, myofascial release, traction, electrical muscle stimulation and massage. At one point the patient was prescribed a cane. On 2/24/03 a "Physical Performance Evaluation", comprised of computerized spinal range of motion exam and computerized muscle testing exam, was performed. The exam was performed by Michael Margolies, D.C. The report now indicates the diagnosis as lumbar disc disorder, unspecified and thoracic hyperflexion/hyperextension. Through the course of treatment the pain drawings indicate pain all over the upper body, except for the upper extremities. The last Daily Progress Notes available for review is dated 5/9/03. It indicates the patient's subjective complaint as back and neck pain. the back pain was patient-rated as 4/10 and the neck was 7/10. Objective findings were increased lumbar spasms, and increased lumbar tenderness. Analysis section indicated an exacerbation due to "positioning." Treatment continued to remain the same as at the start of treatment with the addition of therapeutic exercise. The "Remarks" section of the note indicates the patient complains of increasing pain from her neck down to the low back and is now having headaches. None of the chart notes indicate any diagnosis at any time. Through out the course of treatment there were multiple re-evaluations, with reports, that basically repeated the same information.

On 3/19/03 Richard Lane, D.O. performed trigger point injections at multiple sites in the low thoracic region and lumbar area. There did not appear to be any ill-effects from the injections. The daily progress notes for 3/28/03, 9 days after the trigger point injections, the patient returned after being out of town for a week. The patient complained of "a pulling sensation of the lumbar area." The patient stated that when she woke up she could not walk and is stressed. On 3/31/03 a mobile ultrasound unit was used to perform sonography of the patient's lumbar area (a non-obstetric scan) which was unremarkable. The results were interpreted by Marvin Goldman, MD and Alex Kaliakin, D.C. in Santa Monica, California.

On 4/7/03 Neurotherapy Center of Dallas, Inc. performed an EMG/NCV with results "These findings were felt to be within the normal range of variation. SEP suggested LR and S1 radiculopathy on the left. (It is noted the patient frequently complained of bilateral radiculopathy).

On 4/15/03 Dr. Margolies performed another "Physical Performance Evaluation." On 5/6/03 Dr. Margolies performed a third "Physical Performance Evaluation." On 6/27/03 Dr. Margolies ordered an MRI of the lumbar spine without contrast enhancement. The results were unremarkable with no evidence of any nerve tissue involvement. On 4/7/03 Dr. Margolies ordered an EMG/NCV study that was performed by Mobile EMG, Inc. The report fails to indicate if the EMG was done with needles or surface recording electrodes. The results were unremarkable.

Dr. Margolies of Multicare Medical Group prepared an Impairment Report that indicated a rating of 10% whole body. On 10/23/03 Churchill Evaluation center prepared and submitted a Report of Medical Evaluation. Carlos Porter, M.D. indicated he used the AMA Guides utilizing the DRE model and not the ROM model and there was no impairment awarded for range of motion deficit in the lumbar spine. Dr. Porter determined a whole body rating of 10% and that maximum medical improvement has been reached 8/12/03.

The last Follow Up Examination performed by Richard Lane, D.O. is dated 8/28/03. The report indicates the patient presented with back pain with movements. He noted some improvement but does not describe the amount of improvement or how it was determined. His assessment was lumbar disc herniation (although the MRI clearly did not demonstrate any herniations impinging on nerve tissue) and recommended continued physical therapy, Xanax and Motrin with a review in one week.

There is no evidence the patient was ever released from active care, as far as chart notes indicate.

Questions for Review:

Dates of Service 2/24/03–5/20/03

Is medical necessity shown for #99090–analysis of clinical data, #97550–physical performance evaluation, #E1300–whirlpool, #20550–injection, #99213–office visit, #97265–joint mobilization, #97250–myofascial release, #97122–manual traction, #97110–therapeutic exercises, #A0100–non–emergency transportation, #E1399–durable medical equipment, #E0745–NMS, #A4630–replacement batteries, #99273–consultation, #76856–WP–echography, #99214–office visit?

Explanation of Findings:

The documentation provided clearly indicates a lumbar sprain/strain, with the emphasis on strain. It should be noted, at this point, that the documentation does not indicate the patient received any chiropractic care although the treating doctor is shown as Michael Margolies, D.C. It is not known if the Texas State Board of Chiropractic Examiners has regulations requiring that chiropractic manipulation be provided to a patient being seen by a doctor of chiropractic. If there is such a requirement, this doctor of chiropractic is in violation of such requirements. It is unclear who is actually providing the treatment to the patient as the Daily Progress Notes do not indicate any physician's name. Another name that appears on the Follow Up Examinations is Richard Lane, D.O. It is unclear why the follow up examination are under the name of Richard Lane if Dr. Margolies is the treating doctor of chiropractic. The question is raised of why Dr. Lane and Dr. Margolies are both involved in the case and who is the primary treating physician, if there is even one. The Daily Progress Notes are of the “pigeon hole variety” with use of x's, circles, etc. None of the chart notes indicate any measurable objective findings on every visit as well as other information as required by federal regulations and professional standards. The chart notes indicate the patient was basically receiving passive physical therapy modalities/procedures such as joint mobilization, myofascial release, massage, heat, electrical stimulation, traction on every visit with minor variations, until 3/3/03 when therapeutic exercise was added and evidently off and on throughout the balance of visits.

The first issue to address is the length of care and number of visits. The ODG's indicate, for a lumbar sprain/strain, “fading of treatment frequency (from up to 3 visits per week to 2 or less), plus active self–directed home physical therapy. Maximum of 10 visits over 8 weeks.” The Milliman Care guidelines as well as the McKesson QualityFIRST guidelines and the UCLA Low Back Study all recommend no more than 4 weeks of passive care.

Milliman Care guidelines indicate “Provide 4 to 8 visits for most patients to provide strengthening, stretching, and stabilization exercises.” (Physical therapy for low back pain).

Physical Rehabilitation – The McKesson QualityFIRST guidelines state, “A home exercise program should be created for the patient to be performed and monitored concurrently with the formal program. Supervised physical rehabilitation should be limited to eight sessions, at a rate not to exceed three sessions per week.”

There is no documentation that clearly establishes the patient was incapable of performing a self–directed home exercise program of strengthening, stretching, increasing flexibility and muscle tone. There is no need shown for exercise in an office or requirement of supervision.

In chapter 12, page 300, the ACOEM guidelines state, “Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms.” There are no high–quality scientific studies that clearly indicate the efficacy of

passive physical therapy modalities/procedures or that they have any significant impact on the patient's outcome.

Passive Physical Modalities – QualityFIRST guidelines indicates, “Studies have yielded mixed evidence regarding whether these modalities have any beneficial effect on clinical outcomes, and the current consensus in the literature is that more good quality clinical studies are needed. Because passive modalities may reinforce to patients an image of illness and disability, they may discourage the preferred early return to light, normal activity.”

Haldeman, et al, indicate on page 862, chapter 44 of Principles & Practice of Chiropractic. “Unfortunately, many of the passive modalities have been overused in day-to-day practice. The reasons for such overuse include habit on the part of the clinician, reimbursement issues, or patient requests for the soothing effect of hot packs and other physical modalities. As a result, passive modalities, once incorporated for valid reasons, are often continued long after their usefulness is over. Consequently, these treatments are often seen as ineffective or unnecessary.”

Addressing the issue of the ultrasound of the lumbar spine, ultrasonography has not been shown to be superior to a complete history and a thorough physical examination. The American College of Radiology, the American Chiropractic College of Radiology and the American Institute of Ultrasound in Medicine, have all issued position statements indicating that “diagnostic ultrasound imaging of the adult spine is not medically necessary, with no proven clinical utility in diagnosis or screening.” The Centers for Medicare & Medicaid Services indicates “Ultrasound diagnostic tests are approved for Category I (cephalography, cardiography, pleural effusion, abdominal, pregnancy, arterial flow and two-dimensional echocardiography (B-Mode); and Category II (B-scan for atherosclerotic narrowing of peripheral arteries and monitoring of cardiac output). There are no other uses indicated.” It is noted that The American Institute of Musculoskeletal Diagnostic Ultrasound, owned by Alex Kaliakin, D.C., is located in Santa Monica, California. The usual process for this service is that a mobile ultrasound unit is sent to the office of the doctor of chiropractic, a technician performs the study, the computer results are forwarded to Santa Monica and interpreted. The treating doctor will then bill a technical component and Dr. Kaliakin bills a professional component, which is evident in the billings on 3/31/03. As previously indicated in this paragraph, there is no medical necessity for ultrasonography of the spine.

As to trigger point injections, the ACOEM guidelines in chapter 12, page 300 states, “Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. As has been shown this patient does not have herniations that impact on nerve tissue or disc bulges that significantly impact on nerve tissue.

There is a question as to the medical necessity of traction. The ACOEM guidelines in chapter 12, page 300 indicates “Traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended.” Blue Cross medical policy states, “Use of mechanized spinal distraction therapy is considered not medically necessary as there is insufficient, convincing evidence in the peer-reviewed literature, in terms of clinical effectiveness and safety to support the use of any method of mechanized spinal distraction therapy for the treatment of low back pain. Specifically, the few studies showing a semblance of efficacy have not demonstrated that mechanized spinal distraction therapy is superior to, or even comparable with, existing treatments.”

The Centers for Medicare & Medicaid Services indicates “There is insufficient scientific data to support the benefits of this technique.” (Vertebral Axial Decompression).

McKesson's QualityFIRST guidelines state, "The AHCPR does not recommend the use of traction for patients who have low back pain. Studies reviewed did not indicate any beneficial effects in terms of pain relief, physiologic status, length of hospital stay, functional outcome, or perception of overall improvement."

A very thorough search of the literature failed to disclose any significant high-quality scientific studies that clearly indicate the efficacy of whirlpool baths or that they have any impact on a patient's outcome, as such a whirlpool bath is not deemed to be medically necessary. A patient could achieve the same effect by using a tub at home with warm water.

The doctor of chiropractic prescribed electrical muscle stimulation and billed the carrier for batteries as well as electrodes. The Centers for Medicare & Medicaid Services indicates "use of neuromuscular electrical stimulation is limited to treatment of muscle atrophy and spinal cord injuries." Blue Cross Medical Policy states, "Electrical Stimulation for Pain and Related Conditions: There is a lack of well-constructed controlled studies that address stimulation variables, outcome measures and electrode placement."

There were three (3) physical performance evaluations performed on this patient. They were comprised of computerized muscle testing and range of motion. The forms indicate diagnoses as lumbar disc disorder, unspecified and thoracic hyperflexion/hyperextension (there is no documentation that indicates the patient experienced a hyperflexion/hyperextension injury) injury. The original patient complaint was of a sprain/strain of the low back. It is inappropriate and not medically necessary to perform either computerized muscle testing or computerized range of motion, as a separate and distinct study for a simple sprain/strain.

There are several forms titled "Documentation of Procedure" that indicate non-emergency transportation (which is for an ambulance). There is no documentation that provides any support for billing a carrier for transportation to the office for treatment. That is the responsibility of the patient not the carrier.

The question is raised relative to the CPT codes use for office visits, particularly code #99214. That code is an E&M code that requires at least 2 of these components, 1) a detailed history, 2) a detailed examination, and a medical decision making of moderate complexity. The diagnosis of sprain/strain does not warrant use of #99214 as none of the requirements have been met.

The use of the code #99273 is inappropriate. That CPT code is for an emergency room visit. The documentation does not indicate the patient required the use of an emergency room or that Multicare Medical Group has an emergency room staffed with trauma nurses and physicians.

The diagnosis billed the carrier included 722.93 (Other and unspecified disc disorder, lumbar region.) and 847.1 (sprain/strain thoracic), which is indicated on claim forms for date 2/24/03. On 6/27/03 Dr. Margolies ordered a MRI of the lumbar without contrast enhancement. It is very questionable as to the medical necessity for a MRI ordered 4 months after the date of the alleged injury. It was proved to be not medically necessary as the results were totally unremarkable. The issue of the MRI is raised due to the fact the diagnosis of disc involvement was used to justify treatment and is shown on the physical performance evaluations. The Annals of Internal Medicine indicates "Advanced imaging should be reserved for patients who are considering surgery or those in whom systemic disease is strongly suspected."

The Bulletin on Rheumatic Diseases indicates "MRI studies have revealed the presence of herniated disks in 22% to 40% and bulging disks in 24% to 81% of asymptomatic adults. These studies should be reserved for patients for whom there is a strong clinical suspicion of underlying infection, cancer, or persistent neurological deficit."

Boden, et al, indicates abnormal magnetic resonance scans of the lumbar spine in asymptomatic subjects.

There are three reasons to order an MRI, 1) Progressive neurological deficits; 2) confirmed surgical candidate and the MRI is ordered by the neurosurgeon or orthopedic surgeon; or 3) strong suspicion of

underlying soft tissue pathology demonstrated by clinical symptoms. In the absence of any of these, MRI's are not medically necessary and do not impact the patient's outcome.

On 4/7/03 Dr. Margolies ordered electrodiagnostic testing from Mobile EMG, Inc. Studies using surface recording electrodes are not considered to be in the mainstream of neurological diagnostic testing. Studies have not shown portable nerve conduction devices to be effective diagnostic tools and the results are questionable. Nerve conduction studies have no validity in the absence of needle electromyography because the clinical utility of performing only one study is considered not medically necessary. It is usually the case that mobile electrodiagnostic firms bill for a professional component and the treating doctor bills for a technical component. If the service was provided by a board certified neurologist in an office there would not be separation of the components. There is no medical necessity for mobile testing.

Principles and Practice of Chiropractic indicates in chapter 332, page 647, "The use of erector spinae EMG signal has been researched in an attempt to discern differences between those with low back injury and asymptomatic subjects. Unfortunately, a general consensus on the use of surface EMG in clinical practice is lacking. It is often postulated that those with LBP have an increased level of muscle activity relative to controls. Some studies show no difference between groups, while others show an increase in EMG activity in those suffering LBP." Page 654, "Research on these measures, (surface testing) however, has had mixed outcomes that make it difficult to determine the clinical usefulness of these tests."

The EMG/NCV ordered by Dr. Margolies on 4/7/03 from Neurotherapy Center of Dallas, Inc. indicated lower EMG was to be within the normal range of variation. This is a clear indication of lack of medical necessity to have ordered advanced testing when the symptoms and clinical findings did not warrant such testing. The neurologist also performed SSEP. Blue Cross indicates "Somatosensory Evoked Potential (SSEP) is used for the evaluation of spinal cord lesions secondary to trauma, demyelinating disease, tumor or infection. These studies are appropriate only when a detailed clinical history and neurologic exam and imaging studies and EMG/Nerve Conduction studies have failed to provide adequate information for a specific treatment plan." Again, an advanced service is not shown to be medically necessary.

It is unfortunate chiropractic manipulative therapy was not provided as resolution of the complaint would probably have been achieved instead of months of non-productive care that continued in the absence of resolution.

Notation is made about the repeated follow up examinations allegedly performed by Dr. Lane. It has been previously noted that they all say the same thing. The need for so many re-examinations is not evident and is certainly not supported by other documentation.

The last issue to address is the poor quality of chart notes and other documentation. Haldeman, et al, indicates in chapter 26, pages 487-507 of Principles and Practice of Chiropractic, "Clinical history should include disease history, signs, symptoms, clinical impression, functional diagnosis, management and prognosis." In chapter 27, pages 509-535, "The physical examination should include observation, palpation, red flags, screening tests, percussion and evaluation. In chapter 36, pages 725-741," Documentation and record keeping must include doctor identification, patient identification, patient demographics, patient history, examination findings, findings of special studies, assessment and outcomes instruments, clinical impression, treatment plan, chart/progress notes, reexamination/reassessment; and internal memoranda recording patient visits." "Health records must be legible and should be neat, organized, and complete. Entries in charts should be written in ink. Entries should not be erased or altered with correction fluid (whiteout), tape, or adhesive labels. If the contents of any document are changed, the practitioner should initial and date such changes in the corresponding margin."

In conclusion, medical necessity is shown for visits 2/24/03 through 3/18/03, which is for 4 weeks of physical therapy. Medical necessity is not shown for all other dates than those indicated. Back-to-back daily visits are not shown to be medically necessary. There is a lack of high-quality, scientific studies that clearly indicate any value to daily visits.

The first visit is medically necessary (an appropriate E&M code would be #99203). No other E&M codes are shown to be medically necessary or appropriate.

For the next 3 visits codes electrical stim and myofascial release (#97250) would be appropriate.

For visits after the initial 3 visits, the only appropriate code would be traction (#97122) through 3/18/03.

Medical necessity is not shown for the rest of the services in question. There is excessive use of non-productive passive physical therapy modalities/procedures for a simple sprain/strain.

Conclusion/Decision to Not Certify:

Dates of Service 2/24/03–5/20/03

Is medical necessity shown for #99090–analysis of clinical data, #97550–physical performance evaluation, #E1300–whirlpool, #20550–injection, #99213–office visit, #97265–joint mobilization, #97250–myofascial release, #97122–manual traction, #97110–therapeutic exercises, #A0100–non-emergency transportation, #E1399–durable medical equipment, #E0745–NMS, #A4630–replacement batteries, #99273–consultation, #76856–WP–echography, #99214–office visit?

Medical necessity is not shown for the services in question.

Applicable Clinical or Scientific Criteria or Guidelines Applied in Arriving at Decision:

This decision is based upon documentation, local and national community standards and the following references:

References Used in Support of Decision:

- 1) Occupational Medicine Practice Guidelines, 2nd Edition, American College of Occupational and Environmental Medicine, OEM Press, 2004. Citations are referenced in the text of the discussion.
- 2) Blue Cross Medical Policy. MED.00006.
- 3) Milliman Care Guidelines, Milliman USA, Inc., 10th Edition. Ambulatory Care. Lumbar Pain Section.
- 4) Haldeman, S, et al. Principles and Practice of Chiropractic, Third Edition, McGraw Hill, 2005. Citations are referenced in the text of the discussion.
- 5) Hurwitz EL, Morgenstern H, et al. UCLA Low Back Study. J Manip Physio Ther 2002–25(1) pp 10–20.
- 6) Federal Agency for Health Care Policy and Research, Guidelines for Chart Record Content.
- 7) Bulletin on Rheumatic Diseases, April, 2001.
- 8) Boden SD, Davis DO, Dina TS, et al. Abnormal magnetic–resonance scans of the lumbar spine in asymptomatic subjects. J Bone Joint Surgery 1990;72–1(3): 403–408.
- 9) Jarvik JG, Deyo RA. Diagnostic Evaluation of Low Back Pain with Emphasis on Imaging. Ann Intern Med 2002;137: 586–597.
- 10) QualityFIRST Guidelines, McKesson Health Solutions, LLC. Thoracic and Low Back Pain Section.
- 11) Blue Cross Medical Policy. SURG.00008.
- 12) Straight D. Journal of the American Chiropractic Association, Chiropractic Diagnostic Testing; May 2003, pg 11–18.

- 13) Gose EE, Naguszewski Wk, Naguszewski RK. Vertebral axial decompression therapy for pain associated with herniated or degenerated discs or facet syndrome: An outcome study. *Neurol Res* 1998;20: 186–190
- 14) Hayes Assessment Spinal Unloading Devices for Low Back Pain. September 2001.
- 15) Janke AAW, Kerkow TA, Griffiths HG et al. The biomechanics of gravity–dependent traction of the lumbar spine. *Spine* 1997;22: 253–60.
- 16) American Academy of Neurology. Review of the literature on spinal ultrasound for the evaluation of back pain and radicular disorders. Report of the Therapeutics and Technology Assessment Subcommittees of the American Academy of Neurology. *Neurology* 1998;51: 343–44.
- 17) American Chiropractic Association. ACA Policies on Public Health and Related Matters 2002. Diagnostic ultrasound of the adult spine. Accessed Oct, 2004.
- 18) Blue Cross Medical Policy. MED.00082.
- 19) American College of Radiology. Statement on spinal ultrasound. Reston, VA: ACR;1996.
- 20) Hayes Alert. Technology Assessment Brief. Ultrasonography for the Diagnosis of Spinal and Paraspinal Disorders. Volume VII, Number 4 – April 2004. Lansdale, : A: HAYES, Inc.; 2004 Winifred S. Hayes, Inc.
- 21) American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM). Recommended policy for electrodiagnostic medicine. Endorsed by the American Academy of Neurology, The American Academy of Physical Medicine and Rehabilitation and The American Association of Neuromuscular and Electrodiagnostic Medicine. Accessed June 1, 2005, Updated 2004.
- 22) Stalbert E, Erdem H. Nerve conductive studies, *J Neuro Sci No Bil D*. April–June 2000; 17(2),#18.
- 23) Gose EE, Nagusezewski WK, Nagusezewski RK. Vertebral axial decompression therapy for pain associated with herniated or degenerated discs or facet syndrome: an outcome study. *Neurol Res*. 1998; 20(3): 186–90.
- 24) Hayes Medical Technology Directory, Mechanized Spinal Distraction Therapy for Low Back Pain. Winifred S. Haes, Inc., Lansdale, PA. January 13, 2003.
- 25) Centers for Medicare & Medicaid Services. NCD for Neuromuscular Electrical Stimulation (160.12) Pub. No. 100–3. Man. Sect. No. 160.12I Version No. 1.
- 26) Centers for Medicare & Medicaid Services. NCD for Sensory Nerve Conduction Threshold Tests (160.23). Pub. No. 100.3, Man Sect No. 160.23, Version No. 2
- 27) Centers for Medicare & Medicaid Services. NCD for Ultrasound Diagnostic Procedures (220.5). Pub No 100–3 Manual Sect No 220.5, Version No 1.
- 28) Centers for Medicare and Medicaid Services. National Coverage Determination for Vertebral Axial Decompression NCD#160.16. Effective April 14, 1997.

This reviewer has been provided by a licensed chiropractor in active practice for over twenty years. This reviewer is a Board eligible Chiropractic Orthopedist and is a member of their state Chiropractic Association and the American Chiropractic Association. This reviewer specializes in disability evaluation, industrial injuries, roentgenology and independent medical examinations and is active in continuing education

related to disability and impairment ratings. The reviewer has additional qualifications and training in Acupuncture. This reviewer is certified by their State Chiropractic Association in Industrial Disability examinations and evaluations.

Your Right To Appeal:

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision, the appeal must be made directly to a District Court in Travis County (see Texas Labor Code 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable.

MRIOA is forwarding this decision by mail, and in the case of time sensitive matters by facsimile, a copy of this finding to the treating provider, payor and/or URA, and the DWC.

It is the policy of Medical Review Institute of America to keep the names of its reviewing physicians confidential. Accordingly, the identity of the reviewing physician will only be released as required by state or federal regulations. If release of the review to a third party, including an insured and/or provider, is necessary, all applicable state and federal regulations must be followed.

Medical Review Institute of America retains qualified independent physician reviewers and clinical advisors who perform peer case reviews as requested by MRIOA clients. These physician reviewers and clinical advisors are independent contractors who are credentialed in accordance with their particular specialties, the standards of the American Accreditation Health Care Commission (URAC), and/or other state and federal regulatory requirements.

The written opinions provided by MRIOA represent the opinions of the physician reviewers and clinical advisors who reviewed the case. These case review opinions are provided in good faith, based on the medical records and information submitted to MRIOA for review, the published scientific medical literature, and other relevant information such as that available through federal agencies, institutes and professional associations. Medical Review Institute of America assumes no liability for the opinions of its contracted physicians and/or clinician advisors. The health plan, organization or other party authorizing this case review agrees to hold MRIOA harmless for any and all claims which may arise as a result of this case review. The health plan, organization or other third party requesting or authorizing this review is responsible for policy interpretation and for the final determination made regarding coverage and/or eligibility for this case.

1269265.1

Case Analyst: Lori B ext 569

010407ss

011907lb