

DATE OF REVIEW:

04/13/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97140-59 – manual therapy (unit x 6), 97014 – electrical stimulator (unit x 6), 97035 – ultrasound (unit X 6), and 97110 – therapeutic exercises (unit x 6).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified Chiropractor

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The medical necessity for the requested course of treatment captioned above is not established based on a review of the submitted documentation and consistent with the treatment guidelines referenced.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- MCMC: Case Report dated 03/26/07
- MCMC: Referral dated 03/26/07
- DWC: Notice to MCMC, LLC of Case Assignment dated 03/26/07 from
- DWC: Letter dated 03/26/07 from
- DWC: Confirmation of Receipt of a Request For a Review dated 03/22/07
- LHL009: Request For a Review By An Independent Review Organization dated 03/21/07
- Report dated 03/19/07 from D.C.
- Texas: Facsimile Transmittal Sheet dated 03/12/07 with handwritten comment
- Texas: Handwritten reports dated 03/12/07, 03/06/07
- Notification of Determination dated 03/09/07 from D.C.
- Texas: Office note dated 02/06/07 from D.C.

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that the above captioned individual is a female who was allegedly injured as a result of an occupational injury. The injured individual presented with increased symptoms to the low back.

No mechanism of provocative incident is noted within the documentation. A course of therapy and manual manipulation was recommended by the attending physician (AP). The current diagnosis is lumbar sprain/strain and lumbar segmental dysfunction.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The documentation indicates that the requested course of therapy is in response to a reported flare-up of the condition of record. A review of the documentation reveals that the injured individual is more than two and one half years post injury and also that the injury of record is a non-complicated musculoskeletal injury to the low back. As such, absent documented complicating factors or other issues that would warrant continuing care outside of typical occupational treatment guidelines, there exists no medical necessity for the application of passive care and manual manipulation at this juncture. Also, given the uncomplicated nature of the condition of record, there would be no reasonable expectations for the continued delivery of provider driven care some two and one half years post injury. Lastly, there is no submitted documentation reflecting past care or a complete history of the condition and subsequent treatment to ascertain what past treatment has been rendered and demonstration of positive response to said care.

As such, consistent with the treatment guidelines referenced and given the arguments raised in the above discussion, the medical necessity for the requested course of passive care is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

North American Spine Society Guidelines

Texas Medical Fee Guidelines

Procedural Utilization Guidelines.