

RYCO MedReview

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 07/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Office visits

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

Licensed by the Texas State Board of Chiropractic Examiners

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

A Required Medical Evaluation (RME) with M.D.
Chiropractic therapy with D.C. dated 01/09/07 and 02/09/07
Invoice EOR Summaries

PATIENT CLINICAL HISTORY [SUMMARY]:

Dr. advised against further chiropractic therapy as related to the injury, but recommended an aerobic form of physical exercise and over-the-counter analgesics. Chiropractic therapy was performed with Dr. There were Invoices stating that the chiropractic treatments were not covered because they were not felt to be medically necessary.

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

As indicated in the RME evaluation with Dr., the claimant has episodic lower back pain that seems to be aggravated by prolonged standing and working. Notation indicates the claimant achieved relief with chiropractic care from three days to two weeks at a time. Based upon the Texas Labor Code Section 408.021, employees are entitled to healthcare that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, and/or enhances the ability of the employee to return to or retain employment. Therefore, the claimant does qualify for treatment as described in the Texas Labor Code. Periodic treatment for episodic increases in symptomatology and treatment that allows the claimant the ability to return to gainful employment would be considered to be medically reasonable and necessary. Therefore, the office visits were reasonable and necessary.

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
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Texas Labor Code Section 408.021