

IRO America Inc.

An Independent Review Organization
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DATE OF REVIEW:

JUNE 4, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110-Therapeutic exercises (3 X 4 weeks), 97140-manual therapy, 97014-electrical stimulation, 97035-ultrasound, 97124-massage therapy, 97530-therapeutic activities, 97010-hot/cold packs, S8948-Laser.

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

Board Certified in Chiropractic Care

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

Lumbar MRI dated 5/10/07, Designated Doctor evaluation from DC dated 5/01/07, treatment notes from treating doctor starting from 3/24/07 through 5/01/07, notes dated 4/12/07, and designated doctor notes dated 11/1/06 from MD for a previous injury.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured while working. The patient stated that she was lifting heavy containers of soap and felt pain in her lower back, down the buttocks, pain in the right groin and down her right leg and also in the right lower abdomen.

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

The disputed services listed above are not reasonable or medically necessary based on the below listed criteria. According to the diagnosis given to the injury of lumbar sprain/strain, this is a self-limiting diagnosis that does not require the use of the disputed services. The therapeutic activities, manual therapy, therapeutic exercises, and massage therapy would not be reasonable or necessary as a self directed home exercise program would suffice. Electrical stimulation, ultrasound, laser and hot/cold packs are not reasonable or necessary since this is a self-limiting diagnosis and would have no positive expected outcome any different than that already of the sprain/strain diagnosis. Therefore, the services in dispute are considered not reasonable or medically 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)