



Notice of Independent Review Decision

DATE OF REVIEW: 01/02/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Determine the medical appropriateness of the previously denied request for outpatient chiropractic therapy, three (3) times per week for four (4) weeks for a total of twelve (12) sessions, consisting of one unit of mechanical traction and one unit of chiropractic manipulation per sessions as related to the lumbar spine.

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

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. [The previously denied request for](#) outpatient chiropractic therapy, three (3) times per week for four (4) weeks for a total of twelve (12) sessions, consisting of one unit of mechanical traction and one unit of chiropractic manipulation per sessions as related to the lumbar spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization dated 12/17/07.**

- Company Request for IRO dated 12/14/07.
- Request Form Request for a Review by an Independent Review Organization dated 12/10/07.
- Notice to Inc. of Case Assignment dated 12/18/07.
- Notice of Assignment of Independent Review Organization dated 12/1/07.
- Confirmation of Fax dated 12/17/07.
- Patient Information (unspecified date)
- Lab Work Up dated 12/21/06.
- Notice to Claimant of assigned Physician dated 1/20/07.
- Designated Doctor Evaluation dated 2/10/07.
- Report of Medical Evaluation dated 2/10/07.
- Employer's First Report of Injury or Illness dated xx/xx/xx.
- Lumbar Spine MRI dated 1/26/07, 2/9/06.
- Chiropractic Treatment on 5/30/06.
- Excuse from Work or School dated xx/xx/xx.
- Progress Notes dated 8/25/06, 8/21/06, 8/15/06, 8/11/06, 8/8/06, 8/4/06, 8/1/06, 7/28/06, 7/25/06, 7/20/06, 7/15/06, 7/13/06, 7/10/06, 7/7/06, 7/5/06, 6/28/06, 6/26/06, 6/20/06, 6/15/06, 6/13/06, 6/10/06, 6/8/06, 6/7/06, 6/3/06, 6/1/06, 5/30/06.
- Notice of Utilization Review Findings dated 12/14/07, 11/27/07, 11/19/07, 11/13/07, 11/7/07, 3/29/06, 3/16/06, 2/6/06, 1/23/06.
- Copy of Letter sent to Doctor Results of a Limited Review dated 11/19/07.
- Initial Nursing Assessment/Reassessment Emergency Department dated 12/15/05.
- Emergency Department Treatment Form dated 12/15/05.
- RS Medical Prescription dated 9/22/06, 5/12/06.
- Follow-Up dated 1/3/07, 12/12/06, 12/4/06, 10/23/06, 10/5/06, 9/28/06, 9/14/06, 8/22/06, 8/14/06, 7/24/06, 6/21/06, 6/6/06, 6/5/06, 5/10/06, 4/26/06, 3/29/06, 3/8/06, 3/2/06, 2/20/06.
- Texas Workers' Compensation Work Status Report dated 11/29/07, 11/1/07, 8/6/07, 5/23/07, 4/23/07, 3/26/07, 2/22/07, 2/1/07, 1/9/07, 11/3/06, 11/27/06, 9/6/06, 8/10/07, 6/20/06, 5/30/06, 3/6/06, 2/27/06, 2/13/06, 2/6/06, 1/30/06, 1/23/06, 1/16/06, 1/9/06.
- S.O.A.P. Notes dated 4/24/06, 4/16/06, 4/7/06, 4/5/06, 4/3/06, 1/26/06, 1/24/06.
- Initial Evaluation dated 4/3/06, 1/17/06.
- Follow-Up Report dated 11/29/07, 8/6/07, 5/23/07, 4/23/06, 3/26/07, 2/22/07, 2/1/07, 1/9/07, 11/3/06, 9/28/06, 9/7/06, 8/11/06, 6/21/06, 5/31/06, 4/25/06, 3/28/06, 3/16/06, 3/8/06, 3/2/06, 2/13/06, 2/6/06, 1/30/06, 1/27/06, 1/16/06, 1/9/06.
- Appeal Procedure (unspecified date).
- Cervical Spine X-Ray dated 12/15/05.
- Lumbar Spine X-Ray dated 1/23/06.
- Consultation dated 12/15/05.
- Article (unspecified date).

- Patient Note dated 2/20/06.

NO GUIDELINES WERE PROVIDED BY THE URA FOR THIS REFERRAL.

PATIENT CLINICAL HISTORY [SUMMARY]:

Age: xx years

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Motor vehicle accident.

Diagnosis: 847.9-sprain of unspecified site of back, 847.0-cervical sprain, 847.2-lumbar sprain, 721.3-L2-L5 lumbar facet arthropathy with spondylarthritis, 724.1-thoracic spine pain, 722.11-thoracic IVD without myelopathy ,739.1-subluxation cervical spine, 728.85-muscle spasms and 739.2- subluxation of thoracic spine.

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

This is a xx-year old female who sustained a work related motor vehicle accident injury on xx/xx/xx, when she was sitting in her pick-up truck at a red light and was rear-ended by a dump truck. She is now over two years post injury status. The provided diagnoses include 847.9-sprain of unspecified site of back, 847.0-cervical sprain, 847.2-lumbar sprain, 721.3-L2-L5 lumbar facet arthropathy with spondylarthritis, 724.1-thoracic spine pain, 722.11-thoracic IVD without myelopathy ,739.1-subluxation cervical spine, 728.85-muscle spasms and 739.2- subluxation of thoracic spine. There was a previous peer review from 'Inc., included in this packet dated 11/7/07 which provided a non-authorization determination for outpatient chiropractic therapy three (3) times per week for four (4) weeks for a total of twelve (12) sessions consisting of one unit of mechanical traction and one unit of chiropractic manipulation per sessions as related to the lumbar spine. The report indicated that the claimant had received at least seven (7) sessions of previous physical therapy and at least forty-four (44) chiropractic treatments from 5/30/06 to 10/29/07. The review indicated that the request for 12 more visits was not medically necessary as the provided treatment note documentation dated 5/30/06 to 10/29/07, failed to demonstrate quantifiable evidence of improvements either subjectively or objectively. The employer's first report of injury indicated that the claimant's occupation was a "construction inspector" for the xxxxxx. There was a report of designated doctor medical evaluation which was completed by, DO, dated 2/10/07, which indicated that the claimant had zero (0) percent whole person impairment rating. The designated doctor report on that date indicated that shewais at maximum medical improvement (MMI) status. There were MRI findings of the lumbar spine from 2/9/06, which indicated a left lateral disc protrusion at L5-S1 and associated displacement of the exiting nerve root noted, with minimal degenerative changes as well as some early degenerative disc disease. (The report did not indicate the most recent January 2007 findings). The MRI report of the cervical spine on the same date, indicated only degenerative age appropriate changes with no bulges or compression. An X-ray of the lumbar spine on 1/23/06, revealed narrowing of L4-5 and L5-S1 levels. She had received medications, medical care, physical therapy, a TENS unit, chiropractic care and injections (no specifics indicated in this report). Dr. indicated in his report that her

examination was overall normal for the neck, back and shoulder. Neurological, ranges of motion and orthopedic examination were all normal. Gait was normal. Work restrictions were recommended for this claimant with no lifting over 20 pounds and no pushing or pulling over 30 pounds. The claimant had presented for chiropractic provider driven care with, DC, on 8/29/06, for conservative chiropractic and physical therapy. There were progress notes which did not include a letter head or doctor signature but had dates from 5/30/06 to 8/25/06 for twenty-six dates of service. These notes were unfortunately, entirely illegible due to the handwriting and therefore, could not be deciphered as it relates to this review of records. There was a 12/15/06 X-ray report of the cervical spine which was normal. The claimant was given medical care from, MD initially and throughout 2006-2007, with waxing and waning of her condition, without evidence of any type of curative effects, long term relief effects or symptom resolution from any care received to date. There was a note from a, MD (no specialty indicated) on 2/1/07, indicating that a repeat MRI of the lumbar spine on January 26, 2007, was unchanged other than there was no mention of the actual displacement of the nerve root on the left (but this reviewer finds that there appears to be some worsening) with paraspinal edema noted on the right at L4-5 and greater on the left at L5-S1 and sacral levels. Oddly, this reviewer finds that the actual report of the MRI of the lumbar spine on 1/26/07 does not match this claim entirely. In fact, it showed some worsening with now evidence of a "T11-12 small focus of increased signal intensity posteriorly, consistent with an annular tear" which was not previously noted, as well as new findings of a "very mild L5-S1 retrolisthesis" and new findings of a left lateral and foraminal disc protrusion at L5-S1 with mild left foraminal narrowing and a small left central disc protrusion or inferior disc extrusion. The treatment recommendations from Dr. appear to have involved physical therapy and medication management, as well as referral to a pain management doctor. The report from pain management specialist, MD on 9/28/06, indicated a procedure was performed consisting of "RFTC" of the lumbar facet median branch on the right L2, L3, L4, L5 and S1 levels with another report dated 10/5/06 with same procedure but on the left side. This same doctor had performed trigger point injections into the thoracic spine muscles on 4/26/06. She had presented on 3/2/06 and on 6/6/06 for lumbar epidural injections, on 8/22/06 for bilateral L2 through S1 facet median nerve blocks and on 12/12/06 she had another lumbar L5-S1 ESI procedure performed. There was a follow up report dated 4/23/07, by a Dr., MD, who made an inaccurate statement that the claimant had bulging discs in her cervical spine, per MRI report and also has that in his diagnosis section. However, review of the report by this reviewer indicates a normal study. Nevertheless, she reported no leg pain at that visit and was continuing to receive chiropractic adjustments. The 5/23/07 report from Dr., MD indicated that the chiropractor had offered the claimant spinal decompression treatments with the first one for free and that she did get some relief the from neck and low back pain, with worsening initially then improvement. The chiropractor now wants to get paid for this service. There was a follow-up report from, MD, dated 8/6/07, which indicated that the claimant had also received at least twelve (12) sessions of spinal decompression traction therapy and noted significant improvement in her symptoms, with a claim of "80%" recovery. However, this reviewer cannot appreciate any evidence of actual measurable or demonstratable evidence of subjective or objective documentation reflecting this claim. The current request is to determine the dispute resolution for previously denied outpatient chiropractic therapy, three (3) times per week for four (4) weeks for a total of twelve (12) sessions consisting of one unit of mechanical traction and one unit of chiropractic manipulation per sessions as related to the lumbar spine. There were no specific dates

indicated for this request. Careful review of the provided documentation indicated that there was no evidence of medical necessity for this request and that the denial should be upheld. The reference to support this determination was found within the accepted Official Disability Guidelines, Treatment index, 5th Edition, web based version regarding chiropractic manipulation//therapy and physical therapy modalities of mechanical traction (powered traction and traction) for the low back. The reference specifically indicates that regarding chiropractic manipulation “If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing” and “Many passive and palliative interventions can provide relief in the short term but may risk treatment dependence without meaningful long-term benefit. Such interventions should be utilized to the extent they are aimed at facilitating return to normal functional activities, particularly work.” The recommended duration and frequency indicated for chiropractic manipulation with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity.” Also indicated is that “elective/maintenance care-not medically necessary” and “recurrences/flare-ups-need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months.” This claimant does not have well documented measurable or demonstrable evidence of objective improvements with this chiropractic manipulation treatment plan of at least 44 previous visits and therefore, no further chiropractic manipulation care is deemed medically necessary with the available information. Regarding the requested mechanical traction modality sub reference to traction indicates that “The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica” and “Traction has not been shown to improve symptoms for patients with or without sciatica”. For further sub reference to specifically “powered traction” the reference indicates that it is “Not recommended. While there are some limited promising studies, the evidence in support of powered traction devices in general, and specifically vertebral axial decompression, is insufficient to support its use in low back injuries. Vertebral axial decompression for treatment of low back injuries is not recommended. VAX-D therapy may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention. Decompression therapy is intended to create negative pressure on the spine, so that the vertebrae are elongated, pressure is taken off the roots of the nerve, and a disk herniation may be pulled back into place. Decompression therapy is generally performed using a specially designed computerized mechanical table that separates in the middle. The above information applies to other brands of powered traction devices as well, including DRX and Lordex.” “The efficacy of spinal decompression achieved with motorized traction for chronic discogenic low back pain remains unproved.” Therefore, this request is upheld as a denial at this time, due to the facts that the claimant has far exceeded the guideline recommendations for chiropractic manipulation therapy without quantifiable objective improvements and the lack of support within the guidelines for traction of any kind including mechanical traction, powered traction devices or decompression traction.

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**
The ODG Treatment Index, 5th Edition, web based version regarding chiropractic manipulation//therapy and physical therapy modalities of mechanical traction for the low back. <http://www.odg-twc.com/bp/722.htm#722.1> http://www.odg-twc.com/odgtwc/low_back.htm#chiropractic http://www.odg-twc.com/odgtwc/low_back.htm#manipulation http://www.odg-twc.com/odgtwc/low_back.htm#traction http://www.odg-twc.com/odgtwc/low_back.htm#poweredtractiondevices
- 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)