

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 07/08/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

8 visits of chiropractic treatment (active/passive modalities)

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the 8 visits of chiropractic treatment (active/passive modalities) are not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter from Utilization Management to TMF – 06/30/08
- Information for requesting a review by an IRO – 06/26/08
- Letter of determination– 06/17/08, 06/05/08
- Peer Review Report– 06/16/08, 06/25/08
- Consultation by Dr. – 06/02/08

- Record of peer to peer conversation with Dr. by Dr. 06/06/08
- Designated Doctor Evaluation by Dr. 08/16/07
- Evaluation by Dr. Chiropractic Center – no date

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he was lifting a hose and felt a pop to his lower back resulting in lower back pain and aching. The patient has been diagnosed with lumbar strain, lumbar muscle spasms, and right lower extremity radiculopathy. The patient has been treated with physical therapy, spinal injections, surgery on 08/03/06 and a work hardening program in April 2007. A current MRI of the lumbar spine dated 04/24/08 revealed post-operative changes and multi-level disk protrusions.

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

The most recent records from an orthopedist dated 06/02/08 indicate the exam findings to include: straight leg raise is negative, strength is 5/5, sensory and vascular normal bilateral lower extremities. The only positive exam finding is that of significant muscle spasm right lumbar paraspinals and a mass like effect/trigger point. His subjective symptoms include lumbar spine pain that he rates as 9/10 and he has pain from the shoulder to the leg with numbness and tingling. His extreme high pain rating does not coincide with the minimal physical objective findings documented in the records. He is also working without restrictions.

The ODG's allow for chiropractic care and therapy for injuries of this nature. The guidelines spell out the specific number of visits allowed in the initial phase of treatment. There are no specific guidelines that address continued chiropractic and physical therapy treatment of an injury approximately three years old.

In injuries severe enough to require surgery, there is a reasonable probability that this patient will require some type of treatment on occasion when exacerbations occur. This is what occurred recently. As a result of this flare up in pain, he received 8 chiropractic and physical therapy treatments to include manipulative therapy, ultrasound, therapeutic exercises and traction.

This patient has had sufficient treatment for the injuries he received on the job on 07/15/05. There is no supporting documentation or clinical justification for the requested additional visits. Over the course of his treatment and physical therapy, including his work hardening program in April 2007, the patient should have been instructed in an appropriate home exercise program. As is

documented in the orthopedic report, he is working without restrictions and was advised to take non-steroidal anti-inflammatories and muscle relaxants for pain and discomfort. This recommendation along with the continued home exercise program should be sufficient to manage his ongoing chronic pain and no additional in-office treatment is needed or clinically justified at this time.

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)