I-Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 7/15/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient chiropractic therapy to the lumbar and cervical spine, left shoulder, left elbow, left hip, left knee and left thigh three times a week for two weeks for six sessions to consist of 4 units of therapeutic exercises and 3 units massage

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

Doctor of Chiropractic
AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

Upon independent review the reviewer finds that the requested outpatient chiropractic therapy to the lumbar and cervical spine, left shoulder, left elbow, left hip, left knee and left thigh three times a week for two weeks for six sessions to consist of 4 units of therapeutic exercises and 3 units massage is medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters 6/11/08, 6/24/08
ODG Guidelines and Treatment Guidelines
Letter in response to IRO from 7/3/08

Initial Evaluation Narrative 5/20/08
Consultations 5/29/08, 5/21/08, 5/23/08, 6/16/08, 6/23/08, 6/30/08, 7/3/08
Re-Examination Narrative 6/4/08
Initial Functional Capacity Examination 5/27/08
2nd FCE 7/2/08
MRI Lumbar Spine 6/20/08
, MD 7/1/08, 6/17/08
Pre-Authorization Request 6/5/08
Notice of Disputed Issues 6/9/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was involved in an occupational injury on XX/XX/XX. The injured employee was injured when she slipped and fell. She reports injuries to her cervical and lumbar spine, left shoulder, left elbow, left hip, left thigh, and left knee. The injured employee sought treatment the following day at Chiropractic and was placed into 5 sessions of aquatic and passive therapy. The injured employee was re-examined and 6 sessions of land based therapeutic rehabilitation have been requested. The injured employee was referred to Dr. , who has recommended that the patient continue with therapy. The initial request for 6-sessions was denied; however, it was stated a modification of the number of units would be appropriate.

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

Upon independent review of the provided medical records and ODG Guidelines, this reviewer finds that the requested outpatient chiropractic therapy to the lumbar and cervical spine, left shoulder, left elbow, left hip, left knee and left thigh three times a week for two weeks for six sessions to consist of 4 units of therapeutic exercises and 3 units massage is medically necessary. The injured employee currently does meet the required guidelines for an additional 6-session physical therapy per ODG Admission Criteria:

Review of the ODG below does state that:
Cervical sp/st 10 visits over 8 weeks
Lumbar Sp/st 10 visits over 8 weeks
Hip sp/st 9 visits over 8 weeks
Shoulder Sp/st 10 visits over 8 weeks
Elbow Sp/st 9 visits over 8 weeks
Knee Sp/st 12 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):
10 visits over 8 weeks

Lumbar sprains and strains (ICD9 847.2):
10 visits over 8 weeks
Sprains and strains of unspecified parts of back (ICD9 847):
10 visits over 5 weeks

Sprains and strains of hip and thigh *(ICD9 843):*

9 visits over 8 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):
Medical treatment: 10 visits over 8 weeks

Sprains and strains of elbow and forearm (ICD9 841):
Medical treatment: 9 visits over 8 weeks

Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2):
Medical treatment: 12 visits over 8 weeks

The injured employee's supporting medical documentation is well documented and concurred by other providers. The total units of therapy appear to be medically necessary to properly treat all 6 areas that were injured and are being requested for treatment.

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)**