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Notice of Independent Review Decision

DATE OF REVIEW: 09/26/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy

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:

X 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.

Physical therapy - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbosacral spine interpreted by M.D. dated 03/10/05

A Required Medical Evaluation (RME) with M.D. dated 10/08/07
Chiropractic therapy with D.C. dated 10/12/07, 10/25/07, 01/04/08, and 01/18/08
A letter from Dr. dated 03/24/08
A surgical pathology report interpreted by an unknown provider (no name or signature was available) dated 05/01/08
An RME with M.D. dated 05/20/08
A preauthorization request from Dr. dated 07/16/08
Letters of non-certification, according to the ODG, from D.C. dated 08/04/08 and 08/06/08
A reconsideration request from Dr. dated 08/13/08
A note from an unknown person/provider dated 08/20/08
A TCM Utilization Review Report from Claims Adjuster, dated 08/26/08
A letter of adverse determination, according to the ODG, from D.C. dated 08/27/08
A letter from Attorneys at Law dated 09/09/08
An undated letter from Dr.
The ODG Guidelines were provided by the carrier/URA

PATIENT CLINICAL HISTORY

An MRI of the lumbosacral spine interpreted by Dr. on 03/10/05 revealed advanced degenerative disc disease at L2-L4 with milder changes at L2-L3 and L1-L2. On 10/08/07, Dr. felt the patient's current complaints and treatment were no longer related to the original injury, but recommended a home exercise program and over-the-counter anti-inflammatories. Chiropractic treatment was performed with Dr. on 10/12/07, 10/25/07, 01/04/08, and 01/18/08. On 05/20/08, Dr. recommended maintenance of the nerve stimulator and Ultram. On 07/16/08, Dr. recommended preauthorization for chiropractic spinal pain management. On 08/04/08, Dr. wrote a letter of non-certification for the physical therapy. On 08/13/08, Dr. wrote a reconsideration request letter for the therapy. On 08/27/08, Dr. wrote a letter of adverse determination for the therapy.

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

This patient is a male who is post soft tissue injury of the lumbar spine. He underwent lumbar spine surgery on xx/xx/xx followed by a tertiary program of work conditioning and was determined to have reached MMI as of 06/18/07 with a 20% impairment rating. For the documentation provided, it appears that the patient has had continuous chiropractic treatment with no long term or significant benefit. The treating doctor is recommending that the patient have supportive care on a frequency of once per month. This is not considered to be supportive care but rather maintenance care when a patient is seen on a monthly basis. Evidence based guidelines clearly indicate that supportive care is indicated until a patient has reached MMI and maintenance treatments have been determined. The ODG Pain Chapter in regards to manual therapy and manipulation clearly states that maintenance care is not medically necessary. However, for a patient

who has reached MMI and has sustained a permanent impairment, evidence based guidelines clearly note that the reoccurrence of low back pain is not uncommon, regardless of whether or not the pain is work related. This is clearly stated on Chapter Twelve of the ACOEM Guidelines. If further goes on to state that it is not clear, however, whether a recurrence of the complaint represents a recurrence of a quantifiable physical injury because pain is a subjective experience and the anatomic pathology of regional low back pain has not been well documented. If an underlying condition is aggravated at work, it is important to document the course of pain and activity limitation due to the aggravating factors. Restoration to the prior activity level is the goal and when that level has been reached, the effects of the aggravation can be said to have ceased at that point cure and relief have been accomplished. Evidence based guidelines also clearly differentiate between circumstances involving a recurrence, an aggravation, or exacerbation of a condition. The medical records provided by Dr. do not clearly delineate that any of these situations have occurred to necessitate treatment intervention. The ODG Pain Chapter states again in regard to manual therapy and manipulation that this form of intervention is recommended as an option for low back but if there is a recurrence or flare-up, there needs to be a real evaluation of the treatment's success, and this needs to be clearly documented in the records. Therefore, the requested physical therapy is not reasonable or necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE**

☐ **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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X 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)