



Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 12/15/09

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for:

1. 97140-59-manual therapy one unit for six visits.
2. G0283-Electrical stimulation times one unit for six visits.
3. 97035-Ultrasound one unit for six visits.
4. 98940-Chiropractic manipulation for six visits.

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

Texas licensed chiropractor

**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:

1. 97140-59-manual therapy one unit for six visits.
2. G0283-Electrical stimulation times one unit for six visits.
3. 97035-Ultrasound one unit for six visits.

4. 98940-Chiropractic manipulation for six visits.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Notice of Utilization Review Findings dated 12/23/09.
- Company Request for IRO dated 12/2/09.
- Request for a Review by an Independent Review Organization dated 12/1/09.
- Follow-Up Visit dated 11/3/09, 10/27/09, 10/26/09, 10/19/09, 10/8/09, 9/1/09, 7/15/09, 5/19/09, 3/25/09, 3/3/09, 2/25/09, 2/20/09, 1/5/09, 11/24/08, 11/19/08, 10/17/08, 9/25/08, 9/11/08, 9/2/08, 8/29/08, 8/28/08, 7/7/08.
- Daily Treatment Log dated 7/15/09.
- Disability Evaluating Center dated 3/2/09.
- Pre Authorization Determination dated 11/9/09, 11/5/09, 9/18/09.
- Orthopedic Examination dated 3/2/09.
- Electronic Bill Parties dated 11/23/09.
- Request for Reconsideration dated 6/17/09, 5/5/09, 4/14/09.
- Explanation of Benefits dated 6/22/09, 5/11/09, 4/22/09.
- Pre-Authorization Report & Notification dated 11/23/09, 11/2/09.
- Thoracic Spine X-Rays dated 11/21/08.
- Right Shoulder X-Rays dated 11/21/08.
- Cervical Spine X-Rays dated 11/21/08.
- Lumbar Spine MRI dated 11/12/09.
- Notice of Disputed Issue dated 11/30/09.
- Insurance Claim Form dated 11/12/09, 11/7/09, 10/27/09, 10/9/09, 8/8/09, 6/17/09, 6/5/09, 5/5/09, 4/14/09, 4/2/09, 3/6/09, 3/5/09, 1/6/09, 8/21/06.

There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age: xx**

**Gender: Male**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Sliding**

**Diagnosis: Lumbosacral sprain and lumbago.**

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

This 5'7" tall, 185 pound, male sustained a work related injury on xx/xx/xx, while working. The mechanism of injury was sliding when he felt pain. The provided diagnoses were lumbosacral sprain and lumbago. The claimant had been treating over time with, DC. The claimant received a Texas RME evaluation, on 3/2/09, from orthopedic surgeon DO. Dr. did not feel that any current complaint to

the low back was still related to the xx/xx/xx injury date and that injury had long since resolved. He felt the complaints were an age related disease of life phenomenon. This report indicated that Dr. had also treated a previous xxxx work related low back injury with chiropractic and the claimant was referred for a lumbar epidural steroid injection. It was also noted that the claimant was taking Lipitor, Singulair and Avapro for high blood pressure. There was mention of a previous examination with Dr., on 3/2/07, who found that the claimant had reached maximum medical improvement (MMI) status, on 10/30/06, for his xx/xx/xx injury, and was provided a whole person impairment of 5%. The claimant was now retired. He had no sensory deficits noted. Deep tendon reflexes were symmetrically 3+ at the patella and asymmetrical at 2+ on the Achilles. The right thigh measures 50cm and the left thigh measured 49cm. Dr. noted that the claimant continued to treat ongoing with Dr., at least one time per month. The X-ray report, from 11/21/08, for the thoracic spine, revealed an s-shaped scoliosis curve with multilevel thoracic degenerative disc disease and large syndesmophytes. The right shoulder X-ray, on that date, indicated moderate acromioclavicular joint osteoarthritis and otherwise was normal. The cervical X-ray, of 11/21/08, noted lower cervical spine spondylosis with changes from C5 to T1. There were findings of a left knee MRI, performed on 6/11/08, which identified a complex tearing of the medial meniscus with mild medial compartment osteoarthritis. The progress notes from Dr., from 5/19/09, back to at least 7/7/08, identified ongoing chronic complaints of lumbar spine pain. The progress notes, from 7/15/09, indicated that Dr. was treating the claimant for the knees due to an injury date of xx/xx/xx (no specifics). He was post left and right knee arthroscopic surgery for meniscus tear. The claimant reported 4-5/10 low back pain and manipulation was performed without evidence of physical therapy. The progress notes from Dr. on 9/1/09, documented that the claimant reported a flare up of lower back pain after his knee surgery. There were fixation and spasms noted. He received a manipulation; however, there was no indication of physical therapy. On 9/12/09, Dr. requested 12 visits of physical therapy which were denied. On 10/8/09, there was a follow-up regarding his low back with continued 4-5/10 low back pain in the right lumbosacral region. Lumbar flexion was 75 degrees and extension was 5 degrees. He was provided manipulation. There was no physical modality indicated. On 10/19/09, he had continued problems with his right lower back. There was no indication of physical therapy modalities performed. On 10/26/09, he indicated 9/10 low back pain on the right side and down into the bilateral legs. This pain had increased following his knee surgery which was unrelated to this claim. There was noted decreased perception of vibration and sensory in the right lateral leg compared to the left. Reflexes were noted at 2+ bilaterally. There was normal motor strength except for the right extensor hallucis longus muscle compared to the left. There was no indication of a physical therapy modality provided. The progress notes, from 10/27/09, reported a drop in pain from 8 to a 6/10 after the previous treatment. There were continued spasms noted. There was no notation of physical therapy provided. The notes, dated 11/3/09, indicated continued low back pain was complicating his knee rehabilitation. There was no indication of physical therapy modalities. There was an MRI of the lumbar spine, performed on 11/12/09, which identified T11-12 disc desiccation; L1-2 and L2-3 had mild disc desiccation with 2mm annular disc bulge and tearing; at L3-4 there was a moderate disc

desiccation with loss of vertical disc height. There was noted 2mm of retrolisthesis and a 3mm annular disc bulge with tearing. There was mild bilateral facet joint arthrosis noted. At L4-5 there was moderate disc desiccation and loss of vertical disc height. There was also 2mm of retrolisthesis noted and a 3mm left paracentral disc protrusion with mild impression on the left L5 nerve root in the lateral recess. There was mild bilateral foraminal stenosis without L4 nerve root compression; At L5-S1 there was moderate disc desiccation and loss of vertical disc height. There was 2mm posterior annular disc bulge with tearing. There was moderate right foraminal stenosis with mild compression of the right L5 nerve root in the neural foramen on the sagittal image without significant left foraminal stenosis. A previous review, from 11/6/09, was performed due to a request for physical therapy with chiropractic manipulation for six visits. This was denied due to the fact that he continued to relapse year after year without significant long lasting effectiveness from the ongoing chiropractic and physical therapy treatments received. Dr. requested 6 visits of manipulation with physical therapy on 11/2/09 and again on 11/23/09, both requests were denied. The current request is to determine the medical necessity for dispute resolution regarding CPT codes of 97140-59-manual therapy one unit for six visits, G0283-electrical stimulation times one unit for six visits, 97035-ultrasound one unit for six visits and 98940-chiropractic manipulation for six visits. The medical necessity for this request is not established. The reference to support this adverse determination is found in the ODG, Treatment index 8th edition, web based version with reference to the lumbar spine for recommendations regarding manipulation, manual therapy (physical therapy), electrical stimulation/interferential current and ultrasound. The reference to manipulation indicates that, "For patients with chronic low back pain, manipulation may be safe and outcomes may be good, but the studies are not quite as convincing." The ODG also states that, "Elective/maintenance care – Not medically necessary. Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The claimant continued to receive ongoing treatments for flare-ups that roll one into the next without significant well documented evidence of lasting measurable objective functional improvements. The guidelines would not support ongoing (one or more time per month) manipulation frequency or more than 2 visits, every 4-6 months, for flare ups and recurrences. This would certainly not support these six additional visits requested. For the manual therapy portion of the request, the reference is directed to physical therapy. The reference indicates that, "With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life." Therefore, since there was a lack of improvement with the manual therapy which was provided with manipulation, no further manual therapy is appreciated for medical necessity. For ultrasound 97035, the reference indicates that it is, "Not recommended based on the medical evidence." For electrical stimulation/interferential current G0283, the reference indicates that it is, "Not generally recommended. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder

pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodological issues.” Therefore, in summary, this request is not appreciated for medical necessity or as an effective treatment option and the treatments additionally exceed the recommendations in the guidelines.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 6<sup>th</sup> Edition (web), 2008, with reference to the lumbar spine for recommendations regarding manipulation, manual therapy (physical therapy), electrical stimulation/interferential current and manipulation, ultrasound therapeutic, interferential therapy and physical therapy.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).