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Notice of Independent Review Decision

DATE OF REVIEW: 03/12/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Three sessions over six weeks, chiropractic manipulation, therapeutic exercise, myofascial release techniques, therapies, e-stim, Traction, and ultrasound

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

Diplomate of the American Association of Quality Assurance & Utilization Review
Physicians

Diplomate of the American Academy of Pain Management

Certified by the American Academy of Disability Evaluating Physicians

Fellow of the American Back Society

MD Physician in Training, Resident Year 2

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Chiropractic office notes from D.C., from 06/20/08 thru 01/28/09
2. Designated Doctor Evaluation from M.D., dated 11/04/08
3. Insurance company treatment history form indicating physical therapy from 01/14/08 thru 01/29/09. Different providers for therapy included and the chiropractor,
4. Insurance company list of providers
5. Peer review decision dated 02/05/09
6. Peer review decision dated 02/24/09
7. Medical notes of 01/26/09
8. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee has a past medical history of some form of cervical and lumbar spine disc injury stemming from an incident that occurred in xx/xxxx. The claimant also had a prior ankle injury resulting in surgery to the right ankle in xxxx. The claimant also had a revision surgery in 2002 apparently for another fracture that same right ankle. Additional past medical history included high blood pressure, gastroesophageal reflux disease, diabetes, and morbid obesity. The employee is approximately 5 foot 7 inches with a weight of approximately 241 pounds.

The records suggest that on xx/xx/xx, the employee slipped and fell while at work. She reported multiple injuries including the head, neck, lumbar spine, left leg, right leg, right ankle, and other various body parts.

The employee was seen by physicians at Medical Centers with the documented prior history of back complaints and neck complaints stemming from a xxxx incident. The physicians diagnosed the claimant with multiple sprain/strain injuries and provided referrals for physical therapy as well as medications.

It does appear that multiple visits for physical therapy were provided by Mr. between January, 2008 and February, 2008. The claimant again started receiving physical therapy by Dr. starting in June, 2008 and ending in January, 2009.

When the employee was first seen by Dr. on 06/20/08, it was reported that the employee had low back pain of 8/10, neck pain of 7/10, right hip pain of 7/10, and right ankle pain of 7/10. It was mentioned that she was having a flare-up of her condition, but there was no mention of cause for this "flare-up". The employee was recommended to undergo mainly passive physical therapy modalities and spinal manipulation.

Multiple office visits occurred in the month of June, and by 07/02/08, the employee again had a "flare-up of her low back". The employee was undergoing additional treatments in the form of acupuncture by that time.

As of 08/20/08, a mention was made that the employee was "having a reduction in their symptoms", and this was apparently due to therapy according to the chiropractor. However, pain levels were mentioned as low back pain at 7/10, neck pain at 7/10, right hip pain at 7/10, and right ankle pain at 8/10. No significant change in objective findings were noted, but even though the employee was listing her symptoms as being reduced despite a lack of change in the subjective pain scale, the chiropractor now documented some positive orthopedic tests in the form of Millgram's sign and a straight leg raise on the right. These were not documented in previous examinations on 06/20/08 or 07/02/08.

Another flare-up was mentioned on 09/05/08 along with a statement that the employee was deconditioned on 09/12/08 despite the fact that she had already undergone at least three months of additional chiropractic care with a home exercise program. By 10/01/08, another flare-up had occurred, and on 10/02/08 the employee's pain level was documented at 7/10 for the low back, 7/10 for the neck, 07/10 for the right hip, and 8/10 for the right ankle.

A narrative report was written by Dr. on 10/15/08. It mentions an MRI study of the lumbar spine had revealed a disc herniation at L4-L5 which did compress the thecal sac. A disc bulge was also noted at L5-S1, and there was moderate bilateral foraminal stenosis visualized at that same level. There was no mention of the date of this MRI, and Dr. apparently has not documented that the employee had a prior lumbar and/or cervical spine complaint stemming from as far back as August, 2007. However, he did mention that the employee did have a right ankle surgery in 2000 and 2002. Treatment for this employee, according to Dr. on 10/15/08, was to continue off work status and to continue passive physical therapy modalities as well as active therapeutic exercises.

The records indicate that on 11/04/08, the claimant was seen by M.D., for a Designated Doctor Evaluation. This physician is an orthopedic surgeon, and he performed a thorough review of the records. He did document the multiple physicians that the claimant had already seen including up to eight medical physicians, one physical therapist, and one chiropractor. Dr. did document the employee's prior injuries to the ankle, and he provided an impairment rating to the cervical spine, thoracic spine, lumbar spine, right ankle, and right foot. A combined total whole person impairment was 10% according to this designated doctor.

By 11/13/08, the employee again had a "flare-up" with the same pain levels as mentioned in other dates, and on 12/03/08 another flare-up was documented.

By 01/14/09, the employee was reportedly having a "bad day" with a flare-up. However, pain levels were 7/10 for the low back, 7/10 for the neck, 7/10 for the right hip, and 8/10 for the right ankle.

The employee next sought treatment with physicians at Medical Centers on 01/26/09. It was mentioned that the employee had been seeing a chiropractor for manipulation of the neck and low back. It was also stated that her last visit to the clinic for symptoms related to her "injury of xx/xx/xx" was in May of 2008. It is unclear whether or not this employee was being treated for an xxxx/xxxx injury or the xxxx/xxxx injury since both dates were mentioned in this Medical Centers office note. Nevertheless, the prescription for that day was for Naprosyn, Flexeril, and Vicodin. She was also provided a Toradol shot.

At the present time it appears that Dr. has been attempting to preauthorize additional visits for chiropractic care due to the employee's recurrent flare-up conditions. Two peer reviews provided have denied these requests for additional therapy. Both of these peer reviews were performed in February, 2009 and apparently we are now being asked to perform an IRO decision regarding the medical necessity of three sessions over six weeks of chiropractic manipulation and other modalities.

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

The employee has had numerous visits of physical therapy between January, 2008 and January, 2009. She has also had at least two surgeries on her right ankle and a history of low back and neck pain stemming from an xxxx/xxxx incident. Her current

mechanism of injury includes a simple slip and fall with simple diagnoses of contusions and/or sprain/strain injuries. The current occupational injury of xx/xx/xx was a simple sprain/strain soft tissue injury which is a self-limiting condition. The **Official Disability Guidelines** are very generous in that they do provide an allowance of up to eighteen visits over six to eight weeks, and this treatment is for acute injuries, and there should be a gradual fade of care transitioning to active self-directed care. However, this employee has undergone supervised physical therapy mainly passive modalities since at least June, 2008 and actually even earlier than that since January, 2008 as well. However, most recently the employee has undergone near weekly visits from June, 2008 through January, 2009 under the direction of the chiropractor, Dr. Absolutely no significant objective changes or even subjective changes have been documented in the chiropractic records. The employee still reports the same symptoms whether she is having a “good day or a bad day”. This confirms that the employee has reached a static and stable end treatment point. Additional care is not likely to provide any further benefit. There is no objective evidence that the current chiropractic care has provided any significant benefit, and based on the **Official Disability Guidelines**, the current treatment has been excessive and is no longer reasonable or medically necessary.

In summary, the item in dispute for three sessions over six weeks of chiropractic care, therapeutic exercise, myofascial release, electrical stimulation, traction, and ultrasound is denied. The **Official Disability Guidelines** do not allow for the long-term use of these modalities, especially in light of a lack of objective improvement or functional improvement with previous use of these same modalities.

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

1. *Official Disability Guidelines*