



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 11/26/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of outpatient chiropractic physical therapy two times per week for four weeks consisting of 1 unit of manual therapy and 1 unit of mechanical traction.

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

The reviewer is a Doctor of Chiropractic who has been in practice for greater than 15 years.

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)

The reviewer agrees with the previous adverse determination regarding prospective medical necessity of outpatient chiropractic physical therapy two times per week for four weeks consisting of 1 unit of manual therapy and 1 unit of mechanical traction.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Dr., Dr. and Dr..

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 9/15/10 denial letter, 10/4/10 denial letter, 6/21/10 to 8/27/10 office notes by Dr., 3/22/10 to 7/14/10 encounter summaries by DO, 2/6/09 cervical CT report, x-ray report (Davis series) 4/8/09, 3 view cervical x-ray report 1/10/09, 9/9/10 PT script, 9/27/10 PT script, cervical MRI report 1/10/09 and neurodiagnostic report 8/27/10.

Dr. : medical records invoice (not completed), office notes by Dr. 1/18/10 through 9/29/10, 3/17/10 report by MD, 12/18/08 to 2/23/09 daily treatment logs, 8/27/10 encounter summary by Dr., 7/3/09 PPE report and 9/30/09 FCE report.

Dr. : 10/21/10 office encounter note by PA and 11/8/10 right ankle MRI report.

Dr.: office notes by Dr. 3/2/09 to 1/27/10, various DWC 73 forms, UE evaluations dated 3/25/04 to 2/8/05, 1/29/04 report by , MD, 4/21/09 operative report, 4/9/09 laboratory results, 2/5/09 progress note by MD, office notes by Dr. 11/14/03 through 1/26/09, 1/2/04 right shoulder MRI report and 8/22/03 TMJ x-ray report.

: 11/10/10 letter by, index of documents, 2/11/09 to 9/28/10 PLN 11 reports, 1/2/09 FCE report, 1/10/09 right elbow x-ray report, 1/10/09 ankle x-ray report, 1/10/09 right shoulder MRI report, 1/10/09 lumbar MRI report, 1/10/09 right wrist x-ray report, 1/10/09 thoracic x-ray report, 3/13/09 PPE report, 4/8/09 right ankle MRI report, 4/8/09 right hip MRI report, 5/28/09 PPE report, 7/3/09 PPE report, office notes by Dr. 1/7/09 to 9/29/10, 4/29/09 to 8/10/09 reports by Dr., 8/4/09 FCE report, 2/11/10 electrodiagnostic report, 2/11/10 right hip arthrogram and post MRI report, 12/23/08 to 2/5/09 reports by Dr., daily treatment logs 2/23/09 to 9/9/09, 8/7/09 handwritten office note, 9/10/09 to 8/27/10 office notes by Dr. and 9/4/09 DD report.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a female who was injured in an on the job injury on xx/xx/xx. The records differ on the type of injury sustained. One of the carrier reviewer notes that she was assaulted while the other indicates she slipped and fell on wet ground. The later appears to be correct per the providers' notes for this injury. Her claim includes multiple body areas (shoulder, ankle, cervical spine, and lumbar spine). Diagnostic testing has revealed multiple disc lesions in the cervical spine while electrodiagnostic testing has been interpreted as within normal limits by Dr.. She underwent a surgical procedure to the right shoulder and conservative measures to the remainder of her injury areas. The treating provider is requesting a series of 8 visits consisting of mechanical traction and manual therapy to the cervical spine and right shoulder.

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

The reviewer has reviewed the ODG as it relates to the current request. He feels that the request for manual therapy and manual traction has not been documented enough to establish medical necessity. The ODG notes that traction can be performed with a non-home program utilizing a Saunders or similar supine pneumatic traction device to help treat radiculopathy. However, the notes are not clear as to what type of traction will be performed (i.e. utilizing the

providers hands, an over the door device or pneumatic device). Therefore, the medical necessity has not been established for this procedure.

In a similar note, the request for manual therapy is not specific enough in the documentation. This code can mean many different things as far as how it is applied by the provider. The CPT description is “Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes” Without further information, this code could mean exactly the same thing as the other requested service; therefore, the reviewer notes they cannot approve this 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)**