



Notice of Independent Review Decision

DATE OF REVIEW: 01/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

E-stimulation, manipulation, spinal, three-four regions

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., Diplomate, Congress of Chiropractic Consultants

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Medical necessity has not been established to prove a repeat psychological review and evaluation.

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
722.10	99202		Prosp.						Upheld
722.10	98941		Prosp.						Upheld
722.10	G0283		Prosp.						Upheld

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 10/05, 10/09, 11/03 & 11/10/09, including criteria used in the denial.
3. Orthopedic evaluation and follow up 09/18 & 12/10/09.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The records indicate the patient was injured on the job on xx/xx/xx. He injured his low back and felt a pinch in his low back that extended into the back of his left leg. The patient had received appropriate diagnostic testing and treatment. On 04/21/05 he was placed on MMI and given a 0% impairment rating. He continued treatment through December 2007. No additional treatment was rendered until an office visit in April 2009, about a year with no treatment. No treatment records from that date of service were provided. He was seen on 09/18/09 and that at time recommendation for chiropractic care and therapy was made. Preauthorization was requested and denied. Reconsideration was requested and denied.

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

I have reviewed the records provided. There is not sufficient clinical documentation to warrant the requested treatment plan. The treatment plan does not meet the criteria for the current ODG guidelines for the requested services. The records indicate the patient received proper care at the time of his injury and reached maximum medical improvement. Additional care extended through December 2007. In

conclusion, the requested services are not reasonable, usual, customary or medically necessary to treat this patient's work-related injury.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)