

SENT VIA EMAIL OR FAX ON
Jan/15/2010

Applied Resolutions LLC

An Independent Review Organization
1124 N Fielder Rd, #179
Arlington, TX 76012
Phone: (512) 772-1863
Fax: (512) 853-4329
Email: manager@applied-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/08/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Manipulation spinal three to four regions

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

Chiropractor
AADEP Certified
Whole Person Certified
Certified Electrodiagnostic Practitioner
Member of the American of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 10/12/09 and 11/9/09
Dr. 3/21/08 thru 11/20/09
Letter from Patient 10/20/09

PATIENT CLINICAL HISTORY SUMMARY

The injured worker was injured on xx/xx/xx. The injured employee injured her neck and low back. MRI of the lumbar spine reported a disc herniation at L5-S1. The injured employee underwent physical therapy, medication, active and passive rehabilitation, work hardening

and pain management. The injured employee works as an accountant, walks, limited Yoga, stretches, and rides a stationary bike. The injured employee undergoes a chiropractic manipulation about 1x per month. Records submitted indicate that the injured employee has been riding a recumbent bike 6-10miles, lifting bags of dog food, weight training, kidney problems, and fell and injured her right side. Records submitted do not provide any positive objective orthopedic test. Chiropractic manipulation is being requested for 1x per month for 12 months.

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

The documentation submitted does not meet or support the request for chiropractic manipulation 1x per month for 12 months, which is outside the OD guidelines. ODG recommends 1-2 visits every 4-6 months for recurrence / flare-ups and are not medically necessary for maintenance care. Physical therapy guidelines are 10-12 visits over 8 weeks, which has already been exceeded.

ODG Chiropractic Guidelines:

Therapeutic care –

Mild: up to 6 visits over 2 weeks

Severe:* Trial of 6 visits over 2 weeks

Severe: With evidence of objective [functional improvement](#), total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity

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

* Severe may include severe sprains/strains (Grade II-III⁴) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders)

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#), including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (arthroplasty): 26 visits over 16 weeks

Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks

Intervertebral disc disorder with myelopathy (ICD9 722.7)

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 48 visits over 18 weeks

Spinal stenosis (ICD9 724.0):

10 visits over 8 weeks

See 722.1 for post-surgical visits

Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified (ICD9 724.3; 724.4):

10-12 visits over 8 weeks

See 722.1 for post-surgical visits

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

ACOEM-AMERICA 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)