

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.
12001 NORTH CENTRAL EXPRESSWAY
SUITE 800
DALLAS, TEXAS 75243
(214) 750-6110
FAX (214) 750-5825

Notice of Independent Review Decision

DATE OF REVIEW: June 17, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Comprehensive chiropractic and physical therapy three times a week for six weeks.
CPT: 97110, 97112, 98941, 97012, G0283, 99212.

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Medical records from the Requestor/Provider include:

- Chiropractic and Physical Therapy, 03/22/10, 03/23/10, 04/06/10, 04/07/10, 04/09/10, 04/12/10, 05/03/10, 05/05/10, 05/25/10

Medical records from the URA include:

- Official Disability Guidelines, 2008

Medical records from the Carrier include:

-

PATIENT CLINICAL HISTORY:

Review Outcome: Partially Overturned.

The source for the screening criteria used to make the decision is the Official Disability Guidelines (ODG).

The patient is a female that sustained a neck and lower back work related injury on xx/xx/xx.

The patient had undergone several rounds of physical therapy treatment following the original injury and eventually underwent a cervical fusion.

The next surgery was successful, however, over the years the patient had experienced episodic exacerbations that responded well to physical therapy.

The patient continued to experience chronic lower back pain that eventually led to radicular leg pain. After minimal success in physical therapy, the patient underwent a lumbar laminectomy surgery.

The patient has continued to experience periods of exacerbation of neck and lower back pain which responds positively to physical therapy treatment.

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

With each exacerbation that this patient has experienced, she has experienced a positive outcome with physical therapy. The ODG Guidelines recommends up to six visits of chiropractic manipulative therapy over a two-week period and up to nine physical therapy visits over an eight-week period. The ODG Guidelines recommends myofascial releases as proven treatment in reducing symptoms of referred pain from trigger points, as well as generalized myofascial pain. The ODG Guidelines also recommends chiropractic manipulation as an effective technique for the relief of mechanical back pain.

Since D.C. has demonstrated an objective need for treatment and this patient has received benefits from treatments in the past. The requested plan of 18 visits over a six-week period is beyond the standards set by the ODG Guidelines, however, a plan of three visits per week for the first two weeks and followed by two visits per week, for another two weeks would be within the acceptable standards. The treatments should be limited to chiropractic manipulation or joint mobilization, therapeutic stretching, strengthening, and

myofascial release. The modalities, such as spinal traction and low-level cold laser, are not a recommended therapy under the ODG Guidelines.

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)