

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 6/25/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Chiropractic/Physical Therapy 6 sessions over 4 weeks

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain Management

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)

Chiropractic/Physical Therapy 6 sessions over 4 weeks Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Notice to utilization dated 6/7/2010
2. Notice of assignment dated 6/7/2010
3. Notice of assignment dated 6/7/2010
4. Request form dated 6/3/2010
5. Request form dated 6/3/2010
6. Clinical note dated 6/1/2010
7. Notice of utilization dated 5/27/2010
8. Notice of utilization dated 5/27/2010
9. Letter by author unknown, dated 5/27/2010
10. Letter by author unknown, dated 5/27/2010
11. Letter by author unknown, dated 5/27/2010
12. Reconsideration request MD, dated 5/24/2010
13. Reconsideration request dated 5/20/2010
14. Reconsideration request dated 5/20/2010
15. Reconsideration request DC, dated 5/20/2010
16. Notice of utilization dated 5/17/2010
17. Notice of utilization dated 5/17/2010
18. Notice of utilization dated 5/17/2010
19. Notice of utilization dated 5/17/2010
20. Letter by author unknown, dated 5/17/2010
21. Letter by author unknown, dated 5/17/2010
22. Pre authorization request dated 5/11/2010
23. Clinical note dated 5/11/2010 to 6/3/2010
24. Pre authorization request DC, dated 5/11/2010
25. Pre authorization request DC, dated 5/11/2010

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26. Pre authorization request DC, dated 5/11/2010
27. Letter by Ms, dated 5/10/2010
28. MRI of the lumbar spine dated 5/6/2010
29. MRI of the lumbar spine dated 5/6/2010
30. MRI of the lumbar spine MD, dated 5/6/2010
31. Notice of utilization dated 3/25/2010
32. Evaluation summary dated 3/17/2010 to 6/2/2010
33. Exam summary DC, dated 3/17/2010
34. Daily clinical note DC, dated 3/9/2010
35. Initial narrative report DC, dated 3/10/2010
36. Initial narrative report DC, dated 3/10/2010
37. Re exam report by DC, dated 2/26/2010 to 6/1/2010
38. Requesting IRO dated unknown
39. Form dated unknown
40. Denial information dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The Injured employee is a female who was involved in a work injury on xx/xx/xx. The injured employee is complaining of thoracolumbar pain. An MRI of the lumbar spine dated 5/6/2010 revealed a 3 mm disc protrusion at L3/4. The injured employee has been treated with 12 visits of authorized treatments to date. A new request for 6 additional visits of therapeutic exercise, neuromuscular re-education, myofascial release and therapeutic activity are submitted for review. Re-exam report date 5/10/10 notes constant mild intermittent, moderate, sharp pain from the thoracolumbar junction to the sacrum bilaterally, left more than right. Pain level ranges 2-7 dependent on activity. She has tightness in the bilateral posterior thighs and tingling into feet with certain positions. The exam notes guarding with movement and tenderness in the affected area. Straight leg raises are positive at 50 degrees bilaterally. An FCE 3/17/10 was sedentary-light. 3/18/10 noted completion of 6 initial PT visits including manipulation and therapeutic activity; 4/24/10 noted 6 sessions of active rehab were completed. The provider is requesting continuation of therapeutic treatment plan for 6 more visits. 4/26/10 notes similar subjective complaints as 5/10/10. The initial exam reveals the same subjective complaints.

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

It is unclear from the records submitted the progress of the patient with treatment. The clinical documentation on each date of service 3/10/10, 4/24/10 and 5/10/10 repeats the same subjective clinical complaints and objective physical findings as the presenting complaint on xx/xx/xx making it difficult to discern patient progress to date. There are no individual therapy treatment notes with repeat functional evaluations to assess patient physical capabilities. Without subjective and objective evidence of improvement combined with compelling rationale for additional visits beyond ODG treatment recommendations, continuation of the therapeutic services would not be considered medically necessary based on ODG recommendations. ODG recommends a 6 visit trial of chiropractic and physical therapy services to assess patient progress in order to discern the need for continued therapy. The recommendation is to uphold the 2 previous denials of outpatient chiropractic therapy for 6 sessions over 4 weeks as related to thoracic and lumbar spine consisting of therapeutic exercise, neuromuscular re-education, manual therapy and therapeutic activities not to exceed 4 units per session.

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

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- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)