

Notice of Independent Review Decision

DATE OF REVIEW:

04/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Six sessions of diversified adjustments, neck/back (98943)

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

Board Certified Chiropractor

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: **Upheld**

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The medical necessity for the items in dispute, six sessions of chiropractic treatment is not established.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 04/07/10 xxxx Referral
- 04/07/10 Notice of Assignment of Independent Review Organization, DWC
- 04/07/10 Notice To Utilization Review Agent of Assignment, DWC
- 04/07/10 Notice To xxxx, LLC Of Case Assignment, DWC
- 04/02/10 Request For A Review By An Independent Review Organization
- 04/02/10 Request For IRO For Chiropractic Manipulation fax, xxxxx
- 04/02/10 Request For IRO For Chiropractic Manipulation, Dr. xxxxx
- 03/01/10 non-certification letter, RN, xxxxx xxxxx
- 02/22/10 Request for preauthorization fax, xxxxx
- 02/22/10 Request For Reconsideration For Chiropractic Manipulation, Dr. xxxxx
- 02/01/10 non-certification letter, RN, xxxxx
- 01/26/10 Request for preauthorization fax, xxxxx
- 01/26/10 Pre-Authorization Request, xxxxx
- 01/20/10 Daily Patient Record
- 12/10/09 Letter of Medical Necessity for Evaluation, M.D., xxxxx

- 03/05/10, 11/25/09, 10/09/09, 03/27/09, 11/14/07 Subsequent Evaluations, xxxxx
- 03/05/09 Consultation, M.D., xxxxx
- 01/03/07 to 03/05/10 office visit notes, xxxxx
- 11/11/09 Reconsideration For Physical Therapy, M.D., xxxxx
- 09/12/08 Letter of Medical Necessity for Evaluation, M.D., xxxxx
- 05/27/08 Work Status Report, D.C., DWC
- 04/01/08 to 12/15/09 Subsequent Evaluations, M.D., xxxxx
- 03/26/08 fax cover sheet with note from xxxxx
- 03/25/08 to 11/10/08 Work Status Reports, D.C., DWC
- 06/19/07 to 07/10/09 Subsequent Evaluations, D.C., xxxxx
- 08/14/07 to 03/05/10 Work Status Reports, , DC, DWC
- 01/03/07 Initial Evaluation, D.C., xxxx
- 01/01/04 letter from D.O.
- 09/30/03, 01/20/04 office notes, M.D., xxxxx Group
- 08/19/03 Pain Management Extended Office Visit, M.D., xxxxx
- 07/25/02, 06/06/02 reports from M.D.
- 06/03/02 Report of Medical Evaluation, Dr. DWC
- 05/21/02 Daily Note, Health Centers
- 03/29/02 impairment rating
- 03/27/02 report from M.D.
- 01/25/02 Initial History and Physical, M.D., Center
- 01/25/02 Electromyography/Nerve Conduction Study, Center
- 12/31/01 nerve conduction study of the upper extremities, Associates
- 07/03/01 Follow Up Office Visit, D.O., Spinal Clinic
- 05/07/01 Telephone Consultation note, M.D., xxxxx
- 04/10/01 Initial Office Visit, D.O., xxxxx Clinic
- 03/16/01 report from MSN, NP-C and M.D., xxxxx
- 03/07/01 MRI cervical spine, xxxxx
- 03/07/01 MRI thoracic spine, xxxx
- 03/02/01 Telephone Consultation, MSN, NP-C and M.D., xxxxx
- 01/04/01, 11/17/00, 07/13/00 Follow-Up Visits, xxxxx
- 12/11/00 Initial Office Visit, M.D., xxxxx Clinic
- 10/18/00 MRI left shoulder, xxxxx
- 08/31/00 Initial Consultation, MSN, NP-C and M.D., xxxxx
- 07/26/00 Psychological Reevaluation, PsyD, Clinical Associates
- 05/22/00, 04/10/00 Reevaluation, M.D.
- 04/14/00 CT brain, Imaging Center
- 02/28/00 Neurological Consultation, M.D.
- 02/20/00 Interdisciplinary Treatment Team Review – Narrative Medical Report
- 02/19/00 Evoked Potential Study, M.D.
- 02/19/00 EEG report, M.D.
- 02/19/00 Upper Extremity Evoked Potential Study, M.D.
- 02/16/00 to 04/12/01 chart notes, M.D., xxxxx

- 02/11/00 EMG and Nerve Conduction Study, M.D.
- 02/07/00 MRI cervical spine,xxxxx
- 01/25/00 Initial Evaluation, M.D., xxxxx
- Undated Confirmation Of Receipt Of A Request For A Review, DWC
- Undated Pre-Authorization Request,xxxxx
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

Records indicate that the above captioned individual is a female who presented to the office of the attending provider (AP) complaining of head, neck and shoulder pain that occurred as a result of a reported occupational injury that allegedly occurred on xx/xx/xxxx. To date, she has participated in care to include physical therapy both active and passive, chiropractic care as well as surgeries, counseling and pain management. Surgeries have included rotator cuff repair, rhinoplasty and tear duct dilation. There is little to no clear and unequivocal evidence that the care to date has been therapeutically beneficial or has provided lasting, progressive and significant relief from the reported symptoms.

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

The documentation does not provide the necessary substantiation to establish the medical necessity for the treatment in question. Specifically, the documentation establishes that the injured individual has participated in a litany of care outlined below to include a trial of chiropractic care of at least five visits. One examination report indicates that a trial of twelve visits was initiated on 05/05/2009. Based on the documentation, the injured individual has been basically recalcitrant to care to date with no clear evidence of ongoing progressive or lasting significant relief. The documentation suggests that care to date, to include chiropractic management including joint mobilization and manipulations have been palliative at best. Given the lack of unequivocal evidence of functional improvement in response to a previous course of chiropractic adjustments, the medical necessity for the requested course of additional manipulations is not established. This recommendation is consistent with the Official Disability Guidelines referenced below.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Official Disability Guideline, Neck and Upper Back, Online Version recommended as an option. In limited existing trials, cervical manipulation has fared equivocally with other treatments, like mobilization, and may be a viable option for patients with mechanical neck disorders. However, it would not be advisable to use beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. Further, several reports have, in rare instances, linked chiropractic manipulation of the neck in patients 45 years of age and younger to dissection or occlusion of the vertebral artery. The rarity of cerebrovascular accidents makes any association unclear at this time and difficult to study. (Hurwitz, 2002) (Rothwell, 2001) (Aker, 1999) (Kjellman, 1999) (Gross-Cochrane, 2002) (Ernst, 2003) (Haas, 2003) (Giles, 2003) (Haneline, 2003) (Haas, 2004) (Browder, 2004) (Scholten-Peeters, 2003) (Cote, 2005) (Vernon, 2005) A Cochrane Review concluded that there was strong evidence of benefit favoring “multimodal care”, and the common elements in this care strategy were mobilization and/or manipulation plus exercise. (Gross-Cochrane, 2004) In a recent high quality study, no recommendations were made for or against chiropractic manipulation for WAD patients due to limited evidence, in the form of three non-RCTs published since 1993. Overall, mobilization appears to be the most effective non-invasive form of intervention for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. (ConlinI, 2005) The best evidence synthesis suggests that therapies involving manual therapy and exercise are more effective than alternative strategies for patients with neck pain. (Hurwitz, 2009)

Adverse effects: Recent evidence casts some doubt concerning a causal relationship for stroke, and there is a similar association between chiropractic services and subsequent vertebral artery stroke as also observed among patients receiving general practitioner services. (Haldeman, 2008) Previous studies had suggested more caution concerning the risks of cerebrovascular accidents. (Smith, 2003) (Malone, 2003) (Mitchell, 2004) (Hurwitz, 2004) Adverse reactions to chiropractic care for neck pain may be common and they appear more likely to follow cervical spine manipulation than mobilization. (Hurwitz, 2005) A recent structured review concluded that the exact incidence of vertebral artery dissection (VAD) and stroke following cervical spine manipulation therapy (CSMT) is unknown, but findings in different studies suggest that these complications are more common than reported in the literature. Since there is a large amount of evidence from many reports regarding an association between neurologic damage and cervical manipulation, and because there are no identifiable risk factors, anyone who receives CSMT can be at risk of neurologic damage. It is important for patients to be well informed before undergoing this kind of procedure and for physicians to recognize the early symptoms of this complication so that catastrophic consequences can be avoided. (Leon-Sanchez, 2007) The most serious problems, which some experts now describe as 'well-recognized', are vertebral artery dissections due to intimal tearing as a result of overstretching the artery during rotational manipulation. Most of the incidents reported in case series or surveys had not been previously reported, indicating that under-reporting may frequently be high. These data suggest that spinal manipulation is associated with frequent, mild and transient adverse effects as well as with serious complications that can lead to permanent disability or death. Special caution should be exercised when performing firstline cervical manipulation, and easily understandable information about risks should be included when informed consent is obtained. Therapists should avoid manipulative techniques at all levels of the cervical spine in the presence of any indirect sign of arteriosclerotic disease or in the presence of calcified arterial walls or tortuosities of the vessel. (Ernst, 2007) There was an association between chiropractic services and subsequent vertebral artery stroke in persons under 45 years of age, but a similar association was also observed among patients receiving general practitioner services. This is likely explained by patients with vertebral artery dissection-related neck pain or headache seeking care before having their stroke. (Haldeman, 2008)

Intensity of care: There was an independent association between the type and intensity of initial clinical care and time to recovery. Increasing the intensity of care beyond 2 visits to general practitioners, beyond 6 visits to chiropractors, or adding chiropractic to medical care was associated with slower recovery from whiplash injuries even after controlling for initial injury severity. (Cote, 2005) A single cervical manipulation visit may be sufficient in reducing neck pain at rest and in increasing active cervical range of motion, in subjects suffering from mechanical neck pain. (Martinez-Segura, 2006) Successful outcomes from manipulation are shown in the first few weeks of treatment, without further improvement after additional treatment: the mean effect size at 6 weeks is 1.63; 1.56 at 12 weeks; and 1.22 from 52 to 104 weeks. (Vernon, 2007) A recent high quality study concluded that, although there are few effective treatments of whiplash, increasing evidence suggests that the delivery of intensive healthcare shortly after the injury may lead to iatrogenic disability. Patients who visited general practitioners more than 2 times, visited chiropractors more than 6 times, received combined care from general practitioners and chiropractors, and consulted general practitioners and specialists, all had a longer recovery than patients who visited general practitioners once or twice. Median time to recovery was 323 days in the general medical group, 517 days in the high-utilization general practitioner group, 516 days in the low-utilization general practitioner plus chiropractic group, and 689 days in the high-utilization general practitioner plus chiropractic group. (Côté, 2007) Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that fewer visits would be required in uncomplicated cases.

ODG Chiropractic Guidelines –

Regional Neck Pain:

9 visits over 8 weeks

Cervical Strain (WAD):

Mild (grade I - Quebec Task Force grades): up to 6 visits over 2-3 weeks

Moderate (grade II): Trial of 6 visits over 2-3 weeks

Moderate (grade II): With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, avoid chronicity

Severe (grade III & auto trauma): Trial of 10 visits over 4-6 weeks

Severe (grade III & auto trauma): With evidence of objective functional improvement, total of up to 25 visits over 6 months, avoid chronicity

Cervical Nerve Root Compression with Radiculopathy:

Patient selection based on previous chiropractic success --

Trial of 6 visits over 2-3 weeks

With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity and gradually fade the patient into active self-directed care

Post Laminectomy Syndrome:

14-16 visits over 12 weeks