

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Aug/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT/Chiro Manipulation 1 session/month x 6 months

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

MD, Board Certified Physical Medicine and Rehabilitation

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

Official Disability Guidelines/Neck/Upper Back Chapter

Report of medical evaluation dated 11/18/03

Physical therapy progress notes 11/17/09-03/05/10

Progress notes Dr. dated 10/26/10-06/21/11

SOAP notes D.C. dated 01/12/11-07/20/11

Letters of medical necessity D.C., 2011

Denial Letter, PT / Chiropractic manipulation 1 session / month x 6 months 98941, 97035, 97012, 97110, 97014 dated 07/08/11

Denial Letter, PT / Chiropractic manipulation 1 session / month x 6 months 98941, 97035, 97012, 97110, 97014 dated 07/19/11

Summary of SOAP notes dated 07/26/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. Treatment to date includes lumbar fusion in 1996, carpal tunnel release in March 1997, epidural steroid injections and chiropractic treatment. Comprehensive medical examination dated 10/26/10 indicates that the patient has been undergoing monthly chiropractic visits. Physical examination on 06/21/11 notes right L5-S1 facet area pain. Right straight leg raising produces pulling in the hamstring and buttock. No objective neuro changes. The patient sits listed to the left in exam chair. The request was non-certified on 07/08/11 noting that it is unclear from the clinical documentation how the patient has improved with chiropractic treatment to date. Additionally, it is unclear how many sessions of chiropractic treatment the patient has completed. Letter dated 07/11/11 indicates that the patient has had a mild exacerbation of his work related injuries and has a lot of pain. The denial was upheld on appeal dated 07/19/11 noting that the requested treatment is maintenance treatment and not consistent with guideline recommendations which do allow for short course of care for acute flare-ups only.

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

There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient has undergone a significant amount of chiropractic treatment to date; however, there is no comprehensive assessment of the patient's objective, functional response to this treatment submitted for review to establish efficacy of treatment and support additional sessions. There are no specific, time-limited treatment goals provided. The patient's compliance with a structured home exercise program is not documented. The requested sessions are for maintenance treatment and are not consistent with ODG recommendations. Therefore, the reviewer finds no medical necessity for PT/Chiro Manipulation 1 session/month x 6 months.

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)