

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: November 2, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient chiropractic physical therapy three (3) times a week for two (2) weeks to Lumbar to consist of therapeutic exercises, electric stimulation and massage not to exceed four (4) units per session.

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 Carrier include:

- Chiropractic, 07/18/11, 07/21/11, 07/26/11, 08/01/11, 08/15/11

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Office Note, 07/18/11
- Chiropractic, 07/18/11, 07/21/11, 07/26/11, 08/01/11, 08/15/11, 09/06/11, 09/09/11, 09/21/11, 10/05/11
- 09/27/11, 10/13/11
- 10/18/11
- Texas Department of Insurance, 10/18/11

Medical records from the Provider include:

- Chiropractic, 07/18/11, 07/21/11, 08/01/11, 08/15/11, 09/06/11, 09/09/11, 10/24/11

PATIENT CLINICAL HISTORY:

The patient is a 5'4", 170-pound female who reported a work related injury on xx/xx/xx. According to the patient she was lifting six boxes of cases weighing between 25 to 50 pounds when she began experiencing lower back pain.

On July 18, 2011, the patient presented to D.C., for evaluation and treatment of neck pain, lower back pain, and right leg pain. Dr. diagnosed her with cervical, thoracic, and lumbar sacral and pelvic segmental dysfunction, and thoracic strain/sprain injury. It appears Dr. treated the patient a total of 16 times. Dr. did not perform a Functional Capacity Evaluation to demonstrate functional improvement. In addition his treatment notes between August 15, 2011, and September 9, 2011, did not document objective functional improvement. The ODG Guidelines recommends up to ten sessions over an eight-week period for the diagnosis of strain/sprain injury. The practitioner should allow for fading of treatment frequency from three visits per week to one or less with an emphasis on active, self directed home physical therapy.

Since Dr. did not provide documentation of functional improvement through a Functional Capacity Evaluation or documentation of improvement through objective findings, I see no medical necessity for continued physical therapy.

In reference to the use of electronic muscle stimulation, the ODG Guidelines does not recommend its use. However, this modality has clinically been shown to provide short-term pain relief and increase spinal mobility after injury. However, its use is not recommended after the second week of treatment as it leads to patient and provider dependence, and patients should be transitioned into an active rehab program. Dr. has already utilized this more than two weeks; therefore, I see no medical necessity for continued use of this modality.

In reference to the use of massage therapy, the ODG Guidelines does recommend its use to control pain. The ODG Guidelines recommends up to six sessions over a two-week period. If a chiropractor can demonstrate objective functional improvement, then there is justification for up to 18 sessions over a six to eight week period. Dr. Adams did not document objective functional improvement. As such additional massage therapy is not recommended.

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

The services in dispute were outpatient chiropractic physical therapy to the lumbar spine three times per week for two weeks to consist of therapeutic exercise, electronic muscle stimulation, and massage. The review of the outcome is not approved.

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)