

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 19, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Office Visit (Chiropractic) between 6/19/2012 and 8/18/12.

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

This reviewer is a Board Certified Chiropractor with over 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

03/01/11: Initial Medical Evaluation 03/12/11: MRI Right Shoulder interpreted by
03/30/11: Subsequent Medical Evaluation
03/31/11: Letter of Causation
04/05/11: Consultation
04/12/11: Peer Review
05/25/11: Subsequent Medical Evaluation
06/22/11: Subsequent Medical Evaluation
01/13/12: Peer Review
01/26/12: Report of Medical Evaluation
05/08/12: Medical Side Note
05/16/12: UR performed by MD
05/21/12: Dispute of Peer Reviewer Findings
06/22/12: UR performed by DC

07/02/12: Request for Reconsideration

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured while working. At that time, he experienced immediate onset of pain in his right shoulder with cervical and low back pain experienced the following day. He was initially seen and treated for the right shoulder only and placed on light duty restrictions.

On xxxx, the claimant was evaluated. He presented with complains of pain over the cervical, lumbar, and right shoulder. His pain was rated 5-6/10. On physical examination palpatory assessment indentified moderate muscle spasm over the cervical and upper thoracic paravertebral and right scapular musculatures. Mild muscle spasm was present in the lumbar paravertebral musculatures bilateral. Palpatory tenderness was noted in the cervicothoracic paravertebral (right worse than left) | right AC joint, right bicipital groove, and right scapular musculatures. Trigger pint formation was identified over the thoracolumbar paravertebral region on the right. ROM of the cervical spine produced significant pain towards end ranges limiting range potential. ROM assessment of the lumbar spine produced pain towards end ranges. ROM assessment of the right shoulder produced significant pain towards end ranges. Diagnosis: 1. Cervical sprain/strain versus cervical IVD. 2. Lumbar sprain/strain versus lumbar IVD. 3. Cervical radiculitis. 4. Shoulder sprain/strain versus shoulder internal derangement. Plan: Refer for plain film radiographs and MRI of the cervical, lumbar, and right shoulder, schedule for medical evaluation for medication management, recommend physical medicine and rehabilitation program performed 3 times a week for 4 weeks.

On March 12, 2011, MRI of the Right Shoulder, Impression: 1. Moderate-to-marked right AC joint hypertrophic degenerative changes with mild lateral sloping of the acromion. 2. Mild supraspinatus and infraspinatus tendinopathy. 3. Consider correlation with MR right shoulder arthrogram to better evaluate if clinically warranted.

On March 30, 2011, the claimant was re-evaluated and it was reported the condition of his right shoulder was improving. It was noted the cervical and lumbar regions were not being treated due to failure of the carrier to accept them as compensable. Pain in his right shoulder was rated as 2-3/10. It was noted he was pending evaluation and steroid injection of the shoulder. He was working on restricted duty. Diagnosis: Shoulder RTC syndrome.

On April 5, 2011, the claimant was seen for right shoulder pain. It was noted he had four weeks of physical therapy. On physical examination abduction right shoulder 140, forward elevation 160. Resisted abduction strength 5-/5. Impingement signs are positive. Two views of right shoulder-AC joint arthropathy, glenohumeral joint is well maintained. Type two acromion. Evidence of sterna wires. Diagnosis: 1. Chronic right shoulder pain x one-and-a-half months. 2.

Impingement right shoulder. 3. Rotator cuff tendinitis right shoulder. Plan: Steroid injection right shoulder in conjunction with supervised active rehab program, pain medications, and muscle relaxants.

On April 12, 2011, Peer Review: 1. ...there is no causal relationship between the sequale of the compensable event and the current complaints. There was never a mention of a low back situation. The shoulder pain was noted, and the inclusion of the cervical spine scenario is not a function of trying to fix a leak. 2. The marked acromioclavicular joint arthritis, any pathology in the cervical or lumbar spine, and nay cervical radiculitis or radiculopathy are not related to the on the job injury from 11/23/10. 3.no treatment would be considered reasonable required to address the sequale of this compensable event. 4. ...no future treatment is indicated.

On March 30, 2011, the claimant was re-evaluated and it was reported the claimant had been recommended to have trigger point injection performed to reduce the effects of injury, but the procedure was denied by the carrier.

On June 22, 2011, the claimant was re-evaluated with continued complaints of ongoing upper thoracic and right shoulder pain rated 5-6/10. He also notes pain continues to travel down the right upper extremity to the elbow. On physical examination palpatory assessment identified muscle spasm over the low cervical and upper thoracic paravertebral on the right in addition to the right scapular musculatures. Those regions had moderate tenderness during palpation assessment. Palpatory tenderness was also present over the right subacromial and scapular regions. The claimant was pending BRC hearing.

On January 13, 2012, Peer Review: 1. ...the need for future treatment does not seem to be warranted at this time in accordance to the treatment guidelines to address the sequel of the compensable injury. Based on the described mechanism of injury, the extent of the compensable injury is a mild strain of the soft tissue periarticular musculature of the right shoulder. This injury would be resolved at this time requiring no further treatment other than continuation of a self-directed home exercise program for range of motion and strengthening exercises of the shoulder. 2. There is no indication for ongoing and continued chiropractic treatment at this time in this claimant for the effects of the compensable injury which is felt to be limited to the right shoulder. The claimant was noted to have reached clinical maximum medical improvement as of May 21, 2011, and no additional care is felt to be reasonably required to address the sequel of the compensable injury beyond the date.

On January 26, 2012, a report of medical evaluation by, a doctor selected by the treating doctor, indicate the claimant had not reached clinical MMI. Dr. opined the claimant continued to be symptomatic and had not received a steroid injection recommended by the orthopedist.

On May 16, 2012, MD performed a UR. Rationale for Denial: Based on the clinical information reviewed it appears that the patient has been seen by a

Chiropractor per Peer Review dated 1/13/12 and no supporting documentation was received for review. The peer review also indicates that there is no indication for ongoing and continued chiropractic treatment at this time. The patient was noted to have reached clinical maximum medical improvement as of 5/21/11 and no additional care is felt to be reasonably required to address the sequel of the compensable injury beyond that date. Per Impairment Rating documentation dated 1/26/12, the patient has reached clinical maximum medical improvement. There is no updated office visit note for the patient documenting any new symptoms. The patient's compliance with an active home exercise program is not documented, and there are no specific, time-limited treatment goals provided. Therefore the request for chiropractic office visit is non certified.

On May 21, 2012, DC disputed the Peer Review findings stating Dr. denied chiropractic evaluation because the claimant had obtained maximum medical improvement on May 21, 2011 issued by MD. Dr stated the patient had received a steroid injection to the shoulder. Dr. states this was incorrect because the injection procedure was denied by the carrier and was not performed at all. Dr. argues that the claimant was not allowed adequate care due to repeated denial by the carrier and had not reached MMI. Dr. wished to perform a re-examination to document the patient's status.

On June 22, 2012, DC performed a UR. Rationale for Denial: The original request for a chiropractic office visit was denied based on lack of supporting documentation of any new symptoms. Dr. notes that this patient did receive conservative care at his facility, approximately 9 to 12 visits. He still has pain complaints, and Dr. would like to reevaluate him now in order to determine what if any treatment might be appropriate. This patients' progress is noteworthy for significant administrative issues. The patient was last evaluated on 6/22/11. This patient is still working, and has reported a flare up of pain. I verified with Dr. that this patient was currently working, and had not yet been re-examined. Dr. verified this and explained that it was clinic policy not to reevaluate a patient without first getting preauthorization. Without some objective findings documenting that ODG criteria are met, there are no clinical findings which support the necessity of additional examinations or treatment. This patient is working and his functional status belies the need for additional medical management.

On July 2, 2012 DC requested reconsideration for denial of re-examination. Dr. noted the request was denied by DC because documentation did not support any new symptoms. Dr. argues an examination is needed to document any change in condition. He further stated the claimant contacted the office complaining of increasing pain in the right shoulder. Dr. pointed out that the claimant had been recommend to have trigger point injection to the right biceps tendon and intra-articular injection to the right AC joint, but the procedures were denied by the carrier. Dr pointed out the ODG guidelines would support re-examination.

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

The previous adverse decisions are upheld. As noted in the records reviewed, the claimant injured his right shoulder while working . MRI of the right shoulder performed on March 12, 2011, revealed right AC joint hypertrophic degenerative changes with mild lateral sloping of the acromion. The claimant was placed at clinical maximum medical improvement on 05/21/2011. On July 2, 2012, D.C. requested reconsideration for the previous denial by D.C. of a re-examination. Dr. has not provided past clinical outcomes which supports further care. No treatment goals have been developed to clinically support further examination or treatment. Therefore, the request for Office Visit (Chiropractic) between 6/19/2012 and 8/18/12 is denied per the ODG guidelines.

PER ODG:

Office visits	Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a “flag” to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. <i>Note:</i> The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of “virtual visits” compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy .
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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)**