



Medwork Independent Review

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NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION WORKERS' COMPENSATION - WC

DATE OF REVIEW: 11/12/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Therapy 3x wk for 6wks (manipulation, EMS, ultrasound and massage)

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

Texas State Licensed 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)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Dept of Insurance Assignment to Medwork 10/23/2013,
2. Notice of assignment to URA 10/22/2013,
3. Confirmation of Receipt of a Request for a Review by an IRO 10/23/2013
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 10/22/2013
Adverse determination letter 10/11/2013, referral 9/16/2013, adverse determination letter 9/13/2013, work comp interim report from chiropractic clinic 9/11/2013, preauthorization request form 9/10/2013, letter from physician regarding adverse determination, prescription 9/6/2013, workers compensation initial evaluation report 8/26/2013.

PATIENT CLINICAL HISTORY:

The patient is a male with date of occupational injury of xx/xx/xx. Under review is prior denial of 18 sessions of chiropractic. The reported service dates range from August 26, 2013 through October 11, 2013. The record includes an undated correspondence regarding prior adverse determination from the requesting provider. The provider opined that guideline support up to 25 visits over 6 months for the reported condition. An adverse determination letter was dated October 11, 2013. The primary diagnosis was cervical strain/sprain code 847.0. The adverse



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determination states that the request exceeds evidence-based guideline recommendations. A prior adverse determination was dated September 13, 2013 with similar information.

The attending chiropractor's initial report was dated August 26, 2013. The mechanism of injury was described as about a vehicular incident while employed and working on xx/xx/xx. The complaint list includes the following:

- neck pain rated 9/10 and constant
- midback pain rated 9/10 and constant
- low back pain rated 9/10 and constant
- headaches rated 9/10 and constant
- chest pain rated 9/10 and constant
- right face/jaw pain rated 7/10 and constant

Deep tendon reflexes were reportedly normal. Several provocation maneuvers were noted as positive. There was, however, no clear description of provocation response. Palpation findings noted tenderness throughout the complaint regions. There was, however, no documentation of standardized grading of the aforementioned. Range motion deficits were noted. There was, however, no documentation of measurement method. And, only 1 measurement for our motion was noted. X-rays of the cervical spine were exposed and failed to reveal evidence of acute trauma

The submitted clinical information includes an interim report dated September 11, 2013. Report states the patient has been under care since xx/xx/xx and has made steady improvement.

Symptoms include the following:

- neck pain rated 7/10 and constant
- midback pain rated 6/10 and constant
- low back pain rated 6/10 and constant
- headaches rated 6/10 and frequent
- chest pain rated 5/10 and frequent

Deep tendon reflexes were reportedly normal. Several provocation maneuvers were noted as positive. There was, however, no clear description of provocation response. Palpation findings noted tenderness throughout the complaint regions. There was, however, no documentation of standardized grading of the aforementioned. Range motion deficits were noted. There was, however, no documentation of measurement method. And, only 1 measurement for our motion was noted.

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

Prior adverse determination is upheld. The submitted documentation fails to support medical necessity for services under review. ODG guidelines have provision for an initial trial of 6



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sessions of chiropractic and/or physical therapy for the reported diagnosis. However, guidelines require evidence of objective functional improvement from an initial trial to potentially warrant additional visits. The submitted documentation was insufficient to meet this standard.

Specifically, there was no documentation of patient intake and consent forms, appropriate initial chiropractic history, and examinations with valid/reliable functional data. The initial evaluation documented palpable tenderness but failed to report standardized grading of the aforementioned. Range of motion deficits were noted, however, there was no documentation of measurement method. And, only 1 measurement per our motion was noted. Last, there was no documentation of other valid/reliable functional measures.

Additionally, the request includes passive modalities such as massage, therapeutic ultrasound, and electrical stimulation. The aforementioned modalities are not generally recommended by guidelines stating that there is insufficient high-quality published evidence to support efficacy of passive modalities for the treatment of pain. Moreover, guideline support active procedures stating that the outcomes from the aforementioned are superior to the outcomes from passive modalities. As such, the requested services are inconsistent with cited evidence-based guidelines. Therefore, denial of these services is upheld.

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)