

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: October 10, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chiropractic treatment 2 sessions per week for 4 weeks or 2 sessions per week for 3 weeks and then 1 session per week for 2 weeks (8 sessions).

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

Board Certified Doctor of Chiropractic.

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)

I have determined that the requested chiropractic treatment at the frequency of 2 sessions per week for 4 weeks or 2 sessions per week for 3 weeks and then 1 session per week for 2 weeks (8 sessions) is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 9/20/13.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/18/13.
3. Notice of Assignment of Independent Review Organization dated 7/8/13.
4. Denial documentation dated 8/12/13 and 9/4/13.
5. Letters dated 8/29/13 and 9/18/13.
6. Office visit dated 7/18/13, 7/23/13, 7/26/13, 7/30/13, 8/2/13 and 8/6/13.

7. Treatment Plan/Request for Preauthorization dated 8/7/13.
8. Letter from the patient undated.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx as the result of a strain to the lumbar spine. Subsequently, the patient has been treated for a diagnosis of a lumbar sprain. The clinical notes provided for review indicate that the patient has been receiving treatment with chiropractic manipulation. The clinical notes indicate that the patient has received 6 sessions of spinal manipulation and an ultrasound for his pain complaints. On 8/6/13 the provider documented that the patient reported that he felt about the same as compared to the previous visit. The provider also noted that the patient felt as though he had progressed overall since the initial visit. The patient reported that his pain levels ranged from 0/10 to 8/10. The provider noted that the patient's assessment evidenced decreased pain and increased range of motion as well as improved function and condition with slight improvement. The provider documented manipulation of the left T8, L3, pelvis and right T4, T10 and pelvis with diversified technique.

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

In this patient's case, Official Disability Guidelines (ODG) do not support the requested chiropractic therapy of 2 sessions per week for 4 weeks or 2 sessions per week for 3 weeks and then 1 session per week for 2 weeks (8 sessions). The ODG guidelines indicate that a trial of 6 visits over 2 weeks is supported; and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks if acute. In this patient's case, the documentation provided for review does not evidence objective functional improvement. The clinical note dated 8/6/13 indicates that the patient reported that he felt about the same as compared to the previous visit. The provider also documented that the patient feels as though he has progressed overall since the initial visit. ODG criteria indicates that for recurrences or flare ups of pain, 1 to 2 visits every 4 to 6 months may be supported when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care. According to ODG, functional improvement measures should be used over the course of treatment to demonstrate progress and return to functionality and to justify further use of ongoing treatment methods. The submitted clinical notes lacked evidence of a thorough physical exam of the patient prior to treatment and subsequent to treatment to evidence quantifiable objective functional improvement status post initial treatment. All told, the requested chiropractic therapy of 2 times 4 weeks or 2 times 3 weeks and then 1 times 2 weeks (8 sessions) is not consistent with ODG criteria and therefore is not supported as medically necessary.

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)