



MedHealth Review, Inc.

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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 9/2/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Chiropractic 3x/week for 8 weeks, lumbar, 97012, 97140 and 98942.

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

The reviewer is a Doctor of Chiropractic who is board certified in Chiropractic. The reviewer has been practicing for greater than 20 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Chiropractic 3x/week for 8 weeks, lumbar, 97012, 97140 and 98942.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 8/14/13 letter and treatment plan, 4/16/12 to 6/14/13 chart notes, 11/10/11 lumbar MRI report, 10/17/12 lumbar MRI report, 6/20/11 to 10/1/12 emails, 10/1/12 request to reschedule BRC, 10/25/11 to 11/23/11 notes,

9/10/12 DWC 69 with report, various VISA receipts, 6/20/12 notes, 6/20/11 to 5/24/12 emails/letters from the patient, 8/21/12 report by Exam, 1/24/11 lumbar MRI report, 2/8/10 to 2/11/10 therapy appt card, 6/5/12 letter, various emails between the patient and carrier regarding network issues from March through June 2012, 9/19/12 denial letter, 6/4/12 letter background check.

7/26/13 denial letter, 6/27/13 denial letter, 7/8/13 letter, 4/5/13 reconsideration request, 9/12/12 FCE report, 7/27/11 surgical report,

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, this injured worker felt a pop in his back and went to his knees. He was treated conservatively until surgery was performed in July, 2011.

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

Any additional care would require marked improvement, regardless of the diagnosis. There does not appear to be any improvement with conservative care. SOAP Notes office from 5/10/12, 5/15/12, 5/22/12, 6/4/12, 6/7/12, and 6/14/12 shows pain level same (except 05/15/2012). All chart notes chiropractic services (4/26/13, 4/30/13, 5/3/13, 5/7/13, 5/10/13, 5/14/13, 5/16/13, 5/21/13, 5/24/13, 5/28/13, 5/31/13, 6/4/13, 6/7/13, and 6/14/13.) [14 visits] state no improvement by the patient by the statement, "pain level same." The chart notes on patient from 04/26/2103 through 06/14/2013 states the exact same subjective statement, " ... sought treatment today complaining of continuous sharp, burning, numbing, shooting, tightness, throbbing, and tingling discomfort in the buttocks. He describes that the discomfort is the same with movement. On a scale of 1 to 10, with 10 being the most severe, he describes the intensity as a 9 and indicated that the discomfort occurs approximately 100 % of the time. He states the discomfort is the same since his last visit." The patient also states that physical therapy and chiropractic does not help in the report from TBI.

Therefore, no medical necessity is presented for any additional chiropractic services as no prior improvement has been shown with this care after 20 visits of conservative care with this provider, per the subjective statements from the patient, as provided in the notes. The ODG requires improvement with treatment and it is not present; therefore medical necessity is not established in this case.

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)