

# INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

**[Date notice sent to all parties]:**

**8/4/2015**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: appeal for outpatient chiropractor and physical therapy to the lumbar region for 10 sessions consisting of chiro manipulations, mechanical traction, therapeutic exercises and electrical stimulation**

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

Board Certified PM&R; Board Certified Pain Medicine

**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.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who reported an injury to his low back as a result of a motor vehicle accident on xx/xx/xx. The Emergency Room note dated xx/xx/xx indicates the patient had been struck on the front passenger side and the rear passenger side with subsequent airbag deployment. Severe damage was identified to the vehicle. The patient had complaints of pain located in the lower and upper back. The patient was transported via ambulance with use of a long spine long spine board and C-collar. The patient has been wearing a seatbelt. The note indicates the patient having been prescribed the use of Norco and was circling discharge. The therapy note dated 01/08/15 indicates the patient having completed six physical therapy sessions to date. The patient was able to demonstrate 50% of lumbar flexion/extension as well as 50% of bilateral side bending. The patient was

recommended for additional physical therapy at that time. The clinical note dated 04/29/15 indicates the patient complaining of a continuous sharp, dull, aching and tight feeling with a throbbing quality in the low back. The patient rated the low back pain as 6/10. Pain was also identified at the side of the left hip. Upon exam, tenderness was identified at the bilateral sacroiliac joints as well as the left posterior pelvis and thigh. The clinical note dated 04/30/15 indicates the patient continuing with low back complaints that were rated 7-9/10. The clinical note dated 05/04/15 indicates the patient complaining of increasing discomfort with movement at the left hip and low back. Tenderness identified at both sides of the sacroiliac joint as well as the continued pain at the left hip. The note indicates the patient being recommended for continued therapy. The utilization reviews dated 05/13/15 and 06/26/15 resulted in denials as insufficient information had been submitted regarding the patient's inability to transition to a home exercise program as well as the inclusion of two passive modalities within the request.

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

The documentation indicates the patient complaining of ongoing low back pain despite having previously undergone therapeutic interventions. Additional physical therapy would be indicated provided that the patient meets specific criteria including a reduction in pain along with objective functional improvement identified through the initial course of treatment. Insufficient information has been submitted regarding the patient's continued pain reduction as well as functional improvements, through the prior course of treatment. Additionally, the request includes mechanical traction and the use of electrical stimulation which are not typically utilized for injuries of this nature. Given the completion of a full course of treatment it would be reasonable for the patient progress to a home exercise program. Insufficient information has been submitted regarding the patient's inability to continue to progress towards a home exercise program to address any residual functional deficits. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for the appeal for outpatient chiropractic and physical therapy for the lumbar region for 10 sessions consistent chiropractic manipulations, mechanical traction, therapeutic exercise and electrical stimulation is not recommended as medically necessary.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**  
Manipulation  
ODG Chiropractic Guidelines:  
Therapeutic care –  
Mild: up to 6 visits over 2 weeks

Severe:\* Trial of 6 visits over 2 weeks

Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity

Elective/maintenance care – Not medically necessary

Recurrences/flare-ups – Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care

\* Severe may include severe sprains/strains (Grade II-III1) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders)