

Notice of Independent Review Decision

DATE OF REVIEW: 4/15/15

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Chiro Treatments to Lumbar, Cervical, Thoracic Spine 3 x 3

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

The TMF physician reviewer is a board certified Chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that chiropractic treatments to the lumbar, cervical and thoracic spine 3 times per week for 3 weeks, is not medically indicated to treat this patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker was injured on xx/xx/xx. She presented to the chiropractor on 2/11/15 with complaints of neck, mid-back and low back pain. An adductor stress test was negative for LCL strain/weakness bilaterally. The patient was evaluated and the treating doctor initially requested 15 chiropractic visits for a treatment plan of 3 times per

week for 3 weeks, then 2 times per week for 2 weeks, and 2 follow-up visits spaced at 2 weeks each. This request was denied and the appeal was also denied. A request was made for chiropractic treatment to the lumbar, cervical and thoracic spine 3 times per week for 3 weeks. This request was denied by the carrier.

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

The records indicate the treating doctor evaluated the patient and, based upon the patient's subjective symptoms and his exam findings, requested chiropractic treatments to the lumbar, cervical and thoracic spine 3 times per week for 3 weeks. The chiropractic and physical therapy guidelines do not allow for the requested number of treatments (9) within the requested time period. The guidelines specifically indicate the need first for a 6-visit clinical trial. Then, if the patient has sufficient documented improvement as required, additional visits may be approved. However, based upon these specific ODG criteria, requesting more treatment beyond an initial 6-visit clinical trial would be considered outside the guidelines. In Texas, the use of ODG's treatment guidelines is required unless there are special circumstances and/or national treatment guidelines that can justify a request outside the guidelines. In this situation, there is not sufficient clinical documentation or national treatment guidelines that can be used to replace the ODG and allow for the requested 3 times per week for 3 weeks. In conclusion, based upon the ODG's criteria, utilizing Chiropractic Guidelines/Physical Therapy Guidelines, the request for chiropractic treatments to the lumbar, cervical and thoracic spine 3 times per week for 3 weeks is not medically necessary to treat this patient's medical condition.

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)