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DATE OF REVIEW: 2/06/2018

IRO CASE # XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Osteopathic Manipulative treatment x 22 visits. Physical Therapy Cervical/Thoracic/Lumbar on XXXX.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D. Board Certified in Physical Medicine and Rehabilitation.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:
This patient was born XXXX. The underlying date of injury is XXXX. The mechanism of injury was a XXXX.

The medical records provide somewhat limited clinical detail. The patient appears to have undergone extensive chiropractic manipulative treatment and/or osteopathic manipulative treatment for neck and shoulder pain.

An x-ray from XXXX describes the absence of fractures of the cervical, thoracic, and lumbar spine. MRI imaging of the lumbar spine of XXXX demonstrates edema of the L4-L5 interspinous space, as well as increased fluid in the L5-S1 facet joint, and a broad-spaced disc herniation at L4-L5 with anulous fibrosis tear.

MRI imaging of the cervical spine of XXXX demonstrated straightening of the normal cervical lordosis as well as multiple discogenic changes. Review in this case concluded that osteopathic manipulative treatment was contraindicated because MRI imaging demonstrated a break in the George's line indicative of ligament damage of the cervical spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
Per ODG references, the requested "Osteopathic Manipulative treatment x 22 visits. Physical Therapy Cervical/Thoracic/ Lumbar on XXXX" is not medically necessary. Official Disability Guidelines cover indications for both physical therapy as well as for chiropractic or osteopathic manipulation. In any of these treatments, there should be a physician history and physical examination outlining the patient's history, physical examination, as well as diagnosis and treatment plan with goals. There is very

limited physician documentation at this time, most of which is handwritten and not clearly legible. The medical records do not clearly outline treatment which has been previously performed, and the records do not clearly interpret the patient's radiographic findings in context of the medical history in order to understand the patient's diagnosis, prognosis, contraindications, and goals of treatment. Without such understanding of the patient's medical history, it is not possible to support any type of treatment as medically necessary. Therefore, the current treatment under review is not 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 KNOWLEDGE BASE
- ☐ 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