

P-IRO Inc.

An Independent Review Organization
1507 Frontier Dr.
Arlington, TX 76012
Phone: 817-235-1979
Fax: 866-328-3894

DATE OF REVIEW: *April 18, 2007*

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110-Therapeutic exercise, 97140-Joint Mobilization, 97035-Ultrasound, 97014-Electrical modality

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

11 treating in the Texas Workers' Comp system as a level II Approved Doctor, Certified Doctor of Chiropractics

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)

97110-Therapeutic exercise, 97140-Joint Mobilization, 97035-Ultrasound, 97014-Electrical modality

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Case Assignment, Denial Letters from the URA, Peer review from DC dated 2/16/07 and DC dated 1/19/07, notes from MD dated 2/13/07, notes from MD dated 3/10/03, notes from MD dated 7/29/06, and treatment notes from 1/04/07 through 3/26/07.

PATIENT CLINICAL HISTORY [SUMMARY]:

The original injury took place while the patient worked as a Roll tender. The patient injured himself as he got pinned between two rolls of paper. In November of 2005, the patient exacerbated the injury by picking up a 60lb weight at the direction of a nurse.

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

According to the below referenced criteria, the services in question would not be considered reasonable or necessary. The passive modalities of 97035-ultrasound and the 97014-electrical modality would be used in the initial treatment of the acute injury, which from the dates in the records, does not comply with this treatment. The 97110-therapeutic exercise and the 97140-joint mobilization also are not reasonable or necessary as this treatment is so far removed from the date of injury. This treatment is not necessary as a home exercise would suffice for the 97110. The 97140 should have been performed much earlier in the treatment plan, rendering the current use of this treatment useless. Therefore, the services in dispute are not reasonable or 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)**