

P-IRO Inc.

An Independent Review Organization

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DATE OF REVIEW: *February 19, 2007*

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97110-Therapeutic exercises, 97112-neuromuscular re-education, 97124-massage, 99213-Office visits, 98943-Chiropractic Manipulative Therapy, and 97039-unlisted modality.

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

Texas Approved Doctor's List Level II, Injury Prevention Specialist-Future Industrial Technology, 11 years of treating doctor experience in the Texas Workers' Compensation Commission system.

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.

98943-Chiropractic Manipulative Therapy dos-6/23/06, 6/27/06, 8/11/06, 8/15/06, 8/17/06, 8/18/06, 12/05/06

99213-office visits dos 6/23/06, 6/27/06

97124-massage DOS 6/15/06, 6/23/06, 6/27/06, 8/11/06, 8/17/06, 8/18/06, 12/05/06
97110-therapeutic exercise DOS 6/15/06, 6/23/06, 6/27/06, 8/11/06, 8/17/06, 8/18/06, 12/05/06
97112-neuromuscular re-education DOS 6/15/06, 6/23/06, 6/27/06, 8/11/06, 8/17/06, 8/18/06, 12/05/06
97039-unlisted modality DOS 6/15/06, 6/23/06, 6/27/06, 8/11/06

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRI of right hand dated May 24, 2006, notes from Center, upper extremity NCV/EMG dated 6/23/2006, notes from MD, notes from MD, notes from MD, operative report dated 11/20/2006, notes from DO, X-Rays of right hand and wrist dated 2/13/2006, and treatment notes from Rehab.

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured employee was injured when he was bent over at the waist and drilling into a metal electrical box with a high-powered drill, when the drill bit jammed and twisted his entire right upper extremity.

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

From the medical records provided and the below referenced criteria, the services in dispute, office are not reasonable or necessary. From the history of the injury and the nature of the injury, chiropractic treatment is not necessary and the stated injury to the neck (sprain/strain) would resolve on its own within 6-8 weeks. Chiropractic treatment to the right wrist or hand is not reasonable due to the self limiting sprain/strain of the wrist and also not reasonable for the fracture to the 5th digit; also rendering the office visits unreasonable or necessary. The therapeutic exercises and the neuromuscular re-education are not reasonable or necessary for the patient's diagnosis of a soft tissue sprain/strain and osseus fracture. The patient should be sent home with a self directed home exercise program if needed but these services are not reasonable and are unnecessary. The massage provided is also unreasonable and unnecessary for the diagnosis given according to the below referenced criteria. The unlisted modality (97039) also appears to be unreasonable due to the lack of specificity and time of attendance per treatment according the CPT code books. This is too general of a code and lacks medical necessity. Therefore, according to the below referenced criteria, the services in dispute are unreasonable and unnecessary.

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)**