



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 08/22/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Six sessions of physical therapy within a two week period consisting of 97113 (4 units), 97124 (2 units), and 97032 (1 unit)

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

Licensed by the Texas State Board of Chiropractic Examiners

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the right knee interpreted by M.D. dated 12/26/06

An Employer's First Report of Injury or Illness form dated xx/xx/xx
Evaluations with D.C. dated 05/10/07, 05/11/07, 05/24/07, 05/29/07, 06/13/07,
06/27/07, and 07/06/07
DWC-73 forms from dated 05/10/07, 05/11/07, and 06/13/07
Assignment of proceeds, lien, and authorization notes dated 05/10/07 and
05/11/07
Chiropractic therapy with Dr. dated 05/21/07, 05/23/07, 06/06/07, 06/11/07,
06/14/07, 06/19/07, 06/20/07, and 06/25/07
An MRI of the right knee interpreted by M.D. dated 05/30/07
Preliminary radiology reports from an unknown radiologist (the signature was
illegible) dated 05/30/07 and 07/11/07
A Functional Capacity Evaluation (FCE) with Dr. dated 06/06/07
An MRI of the lumbar spine interpreted by Dr. dated 06/26/07
A Notice of Disputed Issue(s) and Refusal to Pay Benefits form dated 06/26/07
A letter from Dr. dated 06/27/07
An addendum for an MRI of the lumbar spine interpreted by Dr. dated 06/29/07
A preauthorization request from Dr. dated 07/02/07
A letter of non-authorization from D.C. dated 07/02/07
A letter of non-authorization from Dr. (no credentials were available) dated
07/12/07
A reconsideration request from Dr. dated 07/12/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the right knee interpreted by Dr. on 12/26/06 revealed an osteochondral defect in the medial femoral condyle, joint space narrowing, ACL, medial, and lateral meniscal tears, an MCL sprain, and extensive degenerative changes. On 05/10/07, Dr. recommended aquatic therapy and a repeat MRI of the right knee. Chiropractic therapy was performed with Dr. from 05/21/07 through 06/25/07 for a total of eight sessions. An MRI of the right knee interpreted by Dr. on 05/30/07 revealed slow minimal interval partial resolution of edema in the lateral joint compartment. Based on an FCE with Dr. on 06/06/07, the patient could function at the light physical demand level. On 06/13/07, Dr. recommended an MRI of the lumbar spine and left knee and an evaluation with a pain management specialist. An MRI of the lumbar spine interpreted by Dr. on 06/26/07 revealed multilevel degenerative disc disease and facet disease. On 06/26/07, the insurance carrier limited the patient's injury of xx/xx/xx to both hands, wrists, and right ankle only. It was noted the bilateral shoulders, neck, thoracic spine, and bilateral knees were being covered under the xx/xx/xx injury. On 07/02/07, Dr. requested aquatic therapy three times a week for two weeks. On 07/02/07, Dr. wrote a letter of non-certification for additional aquatic therapy. Preliminary radiology reports from the unknown radiologist on 07/11/07 revealed a non-displaced fracture versus avascular necrosis of the right wrist, a disc protrusion at C5-C6, and a disc bulge at C6-C7. On 07/12/07, Dr. wrote a letter of non-certification for further physical therapy. Dr. wrote a request for reconsideration letter on 07/12/07.

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

Based upon the supplied documentation, it appears the patient has only undergone such treatment for the xx/xx/xx date of injury. The claim for the xx/xx/xx injury has apparently been denied by the carrier pending further investigation. Therefore, the patient was not entitled to undergo treatment to those body areas. Upon resolution and acceptance of the claim by the carrier, the patient's treating physician requested a six visit trial of treatment including aquatic therapy, massage, and interferential treatment to the body injury areas related to xx/xx/xx. This would be considered to be medically reasonable and necessary as related to the ODG physical therapy guidelines. Therefore, my recommendation is for the six sessions of physical therapy within a two week period consisting of 97113 (4 units), 97124 (2 units), and 97032 (1 unit).

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 AND 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 (PROVIDE A DESCRIPTION)**