



# PROFESSIONAL ASSOCIATES

## Notice of Independent Review Decision

### IRO REVIEWER REPORT – WC (Non-Network)

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**DATE OF REVIEW:** 07/11/07

**IRO CASE #:**

#### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Twelve visits of physical therapy three times a week for four weeks to include CPT codes 97110, 97140, and 97530

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

Licensed by the 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**

Evaluations with D.C.

A DWC-73 form from Dr.

A Functional Capacity Evaluation (FCE) with P.T. dated 04/13/07

A preauthorization request from Dr. dated 04/30/07

A letter of non-authorization from D.C. dated 05/03/07

A letter of non-authorization from D.C. dated 05/11/07

A letter of denial from R.N. dated 05/18/07

A letter of medical necessity from Dr. dated 07/02/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Dr. recommended therapy three times a week for four weeks. On 03/15/07, Dr. placed the patient on modified work duty. On 04/13/07, Dr. requested 12 more sessions of physical therapy. An FCE with Ms. on 04/13/07 revealed the patient had a lot of deficits and continued care was recommended. On 04/30/07, Dr. requested preauthorization for 12 more sessions of physical therapy. On 05/03/07, Dr. wrote a letter of non-authorization for further therapy. On 05/11/07, Dr. also wrote a letter of non-authorization for further therapy. On 07/02/07, Dr. continued to request further physical therapy.

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

The patient has completed a conservative care program including passive physical therapy and chiropractic manipulation and demonstrated improvement. She is now ready to progress into an active rehabilitation program to assist her in returning to her pre-injury status to include therapeutic activity, exercise, and manual therapy techniques, which would all be considered medically reasonable and necessary. Therefore, my finding is for approval of 12 physical therapy visits three times a week for four weeks to include CPT codes 97110, 97140, and 97530.

**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)