

Parker Healthcare Management Organization, Inc.

DATE OF REVIEW: MARCH 8, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of physical therapy CPT codes: 97110, 97140 and G0283 for 3 X week X 4 weeks (12 additional visits) (dates listed under denied services as 12.11.06, 12.13.06, 12.14.06, 12.19.06, 12.20.06 and 12.21.06)

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

The reviewer for this case is a doctor of chiropractic peer matched with the provider that rendered the care in dispute. The reviewer is engaged in the practice of chiropractic on a full-time basis.

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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
726.31	97110		Prosp		12.11.06-12.21.06				Upheld
	97140		Prosp		12.11.06-12.21.06				Upheld
	G0283		Prosp		12.11.06-12.21.06				Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO- 72 pages

Respondent records- a total of 91 pages of records received to include but not limited to: TDI-HWCN request for an IRO, Medical records, 11.17.06-12.21.06; Records, 12.11.06, MRI Elbow, 12/06, letters, 12.6.06, 12.14.06, guidelines, chapter 10

Requestor records- a total of 0 pages of records received to include but not limited to:

Faxed request for records 2.19.07; 2.26.07 left voicemail regarding records

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient sustained a work related on the job injury, while employed. The patient sustained an injury to his elbow.

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

The ODG guidelines have criteria set forth determining the amount of therapy that is typical for a strain injury in the elbow region. The requested services are in excess of those criteria. The documentation provided does not clearly demonstrate the need or the necessity or estimated prognosis or benefit from continued care. The documentation provided for review does not clearly demonstrate that previous care had any significant impact on the claimant's injury, as a result, continuing the same form of therapy without previous outcome assessment demonstrating improvement is not supported.

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

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

XX 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)