



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 08/15/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for four weeks to the cervical, right ankle, and left wrist consisting of CPT codes 97110, 97140, G0283, and 97035

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

Board Certified in Orthopedic Surgery

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.

Physical therapy three times a week for four weeks to the cervical, right ankle, and left wrist consisting of CPT codes 97110, 97140, G0283, and 97035 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with , D.C. dated 06/03/08
Preauthorization requests TWCC Advisory 96-11 dated 06/03/08 and 06/12/08
A Notification of Adverse Determination from dated 06/06/08 from , D.C.
A Reconsideration for Physical Therapy from Dr. dated 06/11/08
Another Notification of Adverse Determination from dated 06/20/08 from , D.C.
A subsequent evaluation from Dr. dated 07/09/08
A DWC-73 form dated 07/09/08 from Dr.
An IRO request for physical therapy dated 07/22/08 from Dr.
The ODG Guidelines were not provided by the carrier or URA

PATIENT CLINICAL HISTORY

On 06/03/08, in his initial evaluation, Dr. stated the patient had constant cervical, lumbar, bilateral wrist, and right ankle pain. He stated due to the patient's worsening condition, she would receive active and passive care three times a week for four weeks or 12 sessions. provided Notices of Adverse Determination on 06/06/08 and 06/20/08 for physical therapy three times a week for four weeks for CPT codes 97110, 97140, G0283, and 97035. Dr. addressed a reconsideration for physical therapy on 06/11/08, as the patient was suffering from an exacerbation while performing her home exercise program. He noted he was unaware of anywhere in the ACOEM or any other literature that disallowed a patient's exacerbation. On 07/09/08, Dr. noted the therapy requested continued to be denied and the request had been sent to IRO. The patient was asked to continue her home exercise program. Dr. addressed an IRO request for physical therapy on 07/22/08. He stated the therapy was requested so the patient could be transitioned to a home exercise program and maintain employment. He felt the physical therapy was medically necessary.

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

The patient has received adequate physical therapy to date for this exacerbation, and it would appear she should be able to transition to a home exercise program. If the patient still does not tolerate the home exercise program, then a consultation with an appropriate orthopedic surgeon to evaluate the cervical spine, right ankle, and left wrist would be indicated, as it appears that the patient has plateaued with her treatment received to date. Therefore, physical therapy three times a week for four weeks to the cervical, right ankle, and left wrist consisting of CPT codes 97110, 97140, G0283, and 97035 would not be reasonable or 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 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)