

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: AUGUST 5, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

PT 3xWk x 4Wks left finger 97140, 97530, 97112, 97110, 97010, 97013, 97035

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for PT 3xWk x 4Wks left finger 97140, 97530, 97112, 97110, 97010, 97013, 97035. The number of treatments requested are not considered medically necessary by the ODG Guidelines, which recommend just eight treatments over a five-week period.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/18/08, 6/27/08
ODG Guidelines and Treatment Guidelines
MD, 5/28/08, 6/18/08, 7/16/08, 5/21/08
Left Small Finger Xrays, 6/18/08, 5/21/08
Left Hand Xrays, 5/28/08
PT Prescriptions, 6/18/08, 7/12/08
PT Treatment Notes, 6/28/08, 6/26/08, 6/24/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is an injured worker who caught his finger, fracturing it with an associated laceration. He was treated by closed reduction and casting for three weeks. X-rays then showed good alignment. Strength is excellent with full extension of the proximal interphalangeal joint and distal interphalangeal joint, but apparently he has a lot of stiffness. It is stated there is some "tendon shortening." The request is for four weeks of physical therapy three times a week.

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

As the previous reviewer has suggested, this reviewer also agrees that this patient is a candidate for physical therapy. However, the treating physician in this particular case has recommended a number of treatments which exceed the recommended number in the ODG Treatment Guidelines. The request for three times a week for four weeks, twelve treatments, is outside of recommended evidence-based data in which the ODG Guidelines are derived. The reviewer finds that medical necessity does not exist for PT 3xWk x 4Wks left finger 97140, 97530, 97112, 97110, 97010, 97013, 97035.

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)**