



Specialty Independent Review Organization

## Notice of Independent Review Decision

**DATE OF REVIEW:** 5/21/2008

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of Physical Therapy 2-3 times a week for 4-6 weeks (97110 & 97530).

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

The reviewer is a medical doctor who is board certified in Physical Medicine and Rehabilitation.

**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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Physical Therapy 2-3 times a week for 4-6 weeks (97110 & 97530).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

MD  
Health Center – DC

These records consist of the following (duplicate records are only listed from one source): Records reviewed from MD: notes-4/18/08 – 12/21/07.  
Records reviewed: Denial letter-4/24/08 and 4/30/08; Preauthorization request-4/21/08, Therapy Referral-3/14/08, and Appeal preauthorization denial-4/24/08.

Records reviewed from Health Center – DC: Patient Face Sheet-3/7/08, Impairment Evaluation 4<sup>th</sup> Edition-1/22/08, Physical Performance Evaluation-10/17/07 - 1/22/08, prescription for Theraband-12/21/07, prescription for Wrist cock-up splint-10/11/07, Problem Focused History & Exam-10/4/07 - 2/6/08; various DWC69s; DO Impairment Rating Report-2/29/08; Medical Mgt Ctr EOB-1/9/08; DWC53-11/7/07; denial letter-12/20/07; Open MRI report on right hand-11/6/07; MD Medical Documentation-10/10/07 - 3/21/08.

A copy of the ODG was not provided for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

That patient was injured when sustaining a contusion to the right hand with proximal phalanx fractures. Radiographs on 12/21/07 revealed no fractures. An MRI on 11/6/07 revealed non-displaced fracture of the metaphysis of the proximal phalanx of III. He has also undergone management with activity restrictions and chiropractic management (modalities were offered in 3 visits and an initial OT visit). Four visits of therapy are documented. He underwent a DDE on 2/29/08 by, DO. He was found to not be at MMI. The patient is no longer under the care of DC. He is under the care of Dr. who is requesting more PT.

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

**DECISION.** The reviewer states that according to the ODG, PT (specifically 97110/PT procedure and 97530/therapeutic exercises) for a phalangeal fracture (816.01) is recommended. Six units of each are permitted. According to the records provided, the patient has received 1 unit of 97530/therapeutic exercises and 3 units of 97110/PT procedure. The requested 8-18 PT/OT visits is in excess of the ODG, which would allow for 5 more units of 97530/therapeutic exercises and 3 more units of 97110/PT, therefore the requested -18 PT/OT visits are not medically 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 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)