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## Notice of Independent Review Decision

**DATE OF REVIEW:** 02/23/09

**IRO CASE #:**

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

3x2 PT 97110 97140 97112

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

Licensed in Physical Medicine & 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)

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.

3x2 PT 97110 97140 97112 - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Operative Report, , M.D., 11/30/07
- Examination Evaluation, , Unknown Provider, 02/10/08, 01/13/09, 02/03/09
- Radiology Report, X-ray of right hand (2 Views), , M.D., 01/12/09

- Adverse Determination, 01/19/09, 01/26/09
- Notice of Case Assignment, 02/02/09
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient sustained a hand injury at work with right thumb laceration. Examination of the patient's right hand revealed old healed impaction injury of the right tibial epiphysis. X-rays were taken and surgery was performed.

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

The ODG upper extremity section is reviewed. The information from the records provided note the date of injury xx/xx/xx, and the most recent surgical documentation November 30, 2007, in which removal of deep retained hardware right thumb was performed. A January 12, 2009 MRI report confirmed a healed impaction injury of the distal radius and old avulsion injury of ulnar styloid process with degenerative changes of the scaphoid without any acute bony fracture or changes to the carpus and postsurgical fusion first MP joint. In addition, it is indicated that this MP joint has been fused. Prior physical therapy has already been rendered to this area. Furthermore, a comprehensive pain program has already been completed. The ODG does allow for six postoperative physical therapy visits to include the three codes described above. However, there should be a timely rendition of these treatment modalities and since the surgery occurred in November 2007, at least 14 months has lapsed since then.

In summary, the ODG does not support further structured physical therapy with the above codes at this stage considering the amount of treatment that was already being rendered.

**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)**