

Notice of Independent Review Decision

DATE OF REVIEW: 06/04/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97110 – active physical therapy, left hand/wrist 3 X week X 4 weeks, 5 units per session
 97018 – paraffin bath therapy, left hand/wrist 3 X week X 4 weeks, 1 unit per session

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., Diplomate of Congress of Chiropractic Consultants, 23 years of active clinical chiropractic practice, Texas Department of Insurance Division of Workers’ Compensation Designated Doctor Approved Doctor’s list, Impairment Rating and Maximum Medical Improvement Certified through Texas Department of Insurance Division of Workers’ Compensation

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
814.0	97110		Prosp.						Overturn
814.0	97018		Prosp.						Overturn

INFORMATION PROVIDED FOR REVIEW:

- Case assignment
- Letters of denial, 05/04/09 and 05/04/09 including criteria used in denial
- IRO Summary, 05/22/09
- Hospitalization records including radiology 08/28/08, 08/30/08, 09/02/08, 09/08/08
- Workers’ Compensation Initial Evaluation Report, 04/24/09
- Nerve conduction study/electromyographic results, 03/03/09
- Physical therapy initial report and notes, 12/11/08-01/08/09
- Surgeon’s operative report and followup, 09/08/08-03/10/09
- Chiropractic evaluation, 04/24/09

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

Records indicate the patient was injured during a fall onto the ground while walking. She suffered an intraarticular fracture of the distal radius and ulna. This was corrected with closed reduction and percutaneous pinning.

She received surgical intervention and according to the records had received only seven therapeutic visits over the course of her injury. She continued to experience problems, which necessitated her changing treating doctors. The new treating doctor evaluated her on 04/24/09 and found a continuation of subjective symptoms and objective findings which necessitated his request for additional physical therapy. This request was initially denied. The appeal was also denied

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

In reviewing the records, according to ODG Guidelines, they allow up to sixteen visits for medical treatment as well as sixteen visits for postsurgical treatment for an injury of this nature. The patient has not received therapy for an extended period of time since her injury and appears to have become deconditioned. Therefore, the request by this doctor for the postsurgical rehabilitation treatment is, in fact, reasonable, usual, customary, and medically necessary to treat this patient's on-the-job injury. In conclusion, the requested five units of therapeutic exercises and one unit of paraffin bath on each visit for three visits per week for four weeks for a total of twelve visits is, in fact, medically necessary to treat this patient.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with 22 years of practice established, accepted chiropractic and medical standards.
- _____ Mercy Center Consensus Conference Guidelines.
- _____ Milliman Care Guidelines.
- __XX_ 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 national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)