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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/16/09

**IRO CASE #:**

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

12 sessions of physical therapy for the left wrist twice a week for six weeks to include CPT codes 97110 and 97140

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Hand 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.

12 sessions of physical therapy for the left wrist twice a week for six weeks to include CPT codes 97110 and 97140 - Upheld

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

Evaluations with M.D. on 01/30/09, 03/11/09, 04/07/09, 04/30/09, 05/15/09, 06/05/09, 07/03/09, 08/05/09, 09/17/09, and 10/15/09

A medical records review from M.D. dated 05/11/09

An operative report with Dr. dated 05/18/09

A physical therapy request from Dr. dated 07/09/09

A physical therapy evaluation with P.T. on 08/20/09

A letter of adverse determination, according to the Official Disability Guidelines (ODG) from M.D. dated 08/27/09

A preauthorization request from Dr. (no credentials were listed) for dates of service of 08/27/09 through 10/26/09

A letter of adverse determination, according to the ODG, from D.O. dated 09/03/09

The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

On 01/30/09, Dr. performed a first dorsal compartment steroid injection. On 04/30/09, Dr. recommended surgery to the first dorsal compartment tenosynovitis. A left first dorsal compartment release was performed by Dr. on 05/18/09. On 08/05/09, Dr. recommended an MRA of the left wrist. On 08/20/09, Ms. recommended physical therapy twice a week for six weeks. On 08/27/09, Dr. wrote a letter of non-certification for physical therapy to the right knee and left wrist. On 09/03/09, Dr. also wrote a letter of non-certification for the left wrist.

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

This patient had surgery on 05/18/09 and certainly falls outside of the normal ODG treatment interval for de Quervain's tenosynovitis. This patient has already had a course of physical therapy with regard to this. It is my opinion, based on the fact that the patient falls outside of the ODG Guidelines and has already had physical therapy with regard to this diagnosis, I would not recommend further physical therapy at this time. Therefore, the requested 12 sessions of physical therapy for the left wrist twice a week for six weeks to include CPT codes 97110 and 97140 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)**