



Notice of Independent Review Decision

DATE OF REVIEW: 10/26/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Twelve (12) sessions of physical therapy, beginning date 10/05/09, end date 12/04/09.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., certified in the specialty of Physical Medicine and Rehabilitation with over 30 years of clinical practice, teaching, and review of medical services in the area of Physical Medicine and Rehabilitation, which does include physical therapy services in dispute

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>
71943	97110, 97140		Concurrent	12	09/2/09 – 12/04/09				Upheld

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The medical summary indicates that this individual sustained an injury to the left wrist and left hand on xx/xx/xx while cleaning gauges. She was described as a female employee. Subsequent to this, she was diagnosed with left wrist pain. The patient reported left wrist pain with activities of daily living. The pain was described as constant, throbbing, and dull, and rated as 5/10 to 9/10. Aggravating factors were noted to be lifting, pulling, pushing, and firm grasping, while alleviating factors were rest and medications. Examination revealed mild guarding of the left wrist with motion as well as tenderness at the volar aspect of the wrist, forearm, flexor, and extensor musculature. Left wrist range of motion noted the following: extension 45 degrees, flexion 40 degrees, radial deviation 10 degrees, ulnar deviation 10 degrees. Pain was elicited in all planes of range of motion. Strength was decreased to 60%. Left wrist strength was 3/5 on all ranges of motion. The patient had improvements with her left wrist active ranges of motion and wrist strength. However, she still had the following deficits: ongoing left wrist pain, decreased grip and wrist strength, decreased left wrist active range of motion, and decreased tolerance for lifting, pulling, and pushing activities. The patient was noted per the treating facility to have completed twelve sessions of physical medicine and rehabilitation.

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

The decision to uphold and agree with the previous non-certification for preauthorization of additional twelve sessions of physical medicine was based on the ODG area including the forearm, wrist, and hand. In the ODG Online Internet-based Criteria, it is noted that for the diagnosis relating to sprains and strains of the wrist and hand, nine visits over eight weeks, or also sprains and strains involving elbow and forearm areas, medical treatment of nine visits over eight weeks. Based on the submitted documentation that the patient has had twelve treatment sessions, she has already exceeded the ODG Guidelines for the injured areas and would be anticipated to be on a home exercise program with self-direction. There is no indication within the submitted appeal documentation to exceed any further the ODG treatment criteria.

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 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)