

# I-Resolutions Inc.

An Independent Review Organization  
8836 Colberg Dr.  
Austin, TX 78749  
Phone: (512) 782-4415  
Fax: (512) 233-5110  
Email: manager@i-resolutions.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Apr/18/2010

**IRO CASE #:**

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

12 Additional Physical Therapy visits over 4 weeks for the right wrist using 97110, 97140, and 97112

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

MD, 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG, Forearm, Wrist and Hand  
Adverse Determination Letters, 2/26/10, 3/15/10  
Clinic 3/10/10, 2/19/10, 10/26/09, 10/30/09, 10/9/09,  
10/19/09, 10/21/09, 10/23/09, 1/8/10  
MRloA 2/25/10, 3/12/10  
M.D., P.A. 1/5/10, 10/20/09  
Imaging Center 11/20/09  
Reviews 12/4/09, 11/19/09  
M.D. 9/4/09, 12/2/09  
Solutions 1/25/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a man injured with a reported crush injury on xx/xx/xx. He remains with ongoing pain, a popping sensation and limited motion in his right wrist. The MRI showed no pathology, although there are comments from others of edema and 3rd metacarpal cysts. No specific diagnosis was made. The man had 11 therapy sessions, and apparently 2 more were approved for training in a self directed program. Dr. noted that he still had pain and limited motion and requested 12 additional therapy sessions.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS**

**AND CONCLUSIONS USED TO SUPPORT THE DECISION**

There was no specific diagnosis in the records beyond pain. The claimant's problem is nearly a year old. His treatment to date exceeds the ODG recommendations for nonsurgical management. The requested additional 12 sessions exceeds the number of sessions recommended in the guidelines. The ODG recommends less formal and more self-directed programs. While he has not improved, nothing was provided in the records to suggest that the additional treatment would lead to further improvement. Therefore, the reviewer finds that medical necessity does not exist for 12 Additional Physical Therapy visits over 4 weeks for the right wrist using 97110, 97140, and 97112.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)