INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision
REVIEWER'S REPORT

DATE OF REVIEW: 05/04/11
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical therapy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
D.C., Diplomate, College of Chiropractic Consultants.

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

__X __Upheld (Agree)
_____Overturned (Disagree)
_____Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
354.0	*97110*		*Prosp.*				*09/12/08*	*94997 6180*	*Upheld*

INFORMATION PROVIDED FOR REVIEW:
1. case assignment.
2. Letters of denial 04/01/11 & 04/07/11, including criteria used in the denial.
3. External reviews 04/01/11 & 04/07/11.
4. Impairment rating 01/18/11.
5. Orthopedic consultation 11/23/10.
6. Operative reports 05/27/09, 07/17/09 & 08/2010.
7. Follow up and progress notes 12/29/10 – 04/21/11 (10 reports).

SUMMARY OF INJURED EMPLOYEE'S CLINICAL HISTORY:
The records indicate the patient started having pain in her hands and wrists on xx/xx/xx. She noted that she was having numbness and tingling in bilateral hands, wrists and shoulder. She also had nocturnal pain. The pain would wake her up regularly.

The patient presented to a clinic and chose a treating doctor. She was placed in an active therapy program with some progress. The exact number of therapy visits was not available. She was referred for surgical consultation. She did have subsequent surgery performed on both hands and elbows. She also had surgery on an acquired trigger finger.

She completed her rehab and presented for a MMI/Impairment Rating on 01/18/11. The exam on that date revealed minimal objective findings. She was released to return to work without restrictions as of 01/26/11. Therapy noted dated 03/03/11, 03/04/11 and 03/07/11, were reviewed with no explanation as to the clinical reason for these three therapy visits, especially since the last surgery was performed on 08/20/10. An exam

dated 03/14/11 indicated the patient experienced an exacerbation of her pain. There is nothing in the records specifically detailing the mechanism of her exacerbation. The exam on that date indicates minimal positive orthopedic tests and clinical findings. Over the next several weeks, there were several additional office visits. Pre-authorization was requested for six (6) physical therapy visits. This was denied. Reconsideration was requested and also denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THIS DECISION:
There are no specific ODG guidelines available for physical therapy as it applies to exacerbations of an injury. However, there are specific guidelines regarding the maximum allowable therapy visits for carpal tunnel syndrome/surgical repair and elbow surgical repair. The records indicate this patient has had extensive surgical intervention, as well as extensive post-operative rehabilitation.

She has far exceed the ODG guideline, and there is no documentation or clinical justification to warrant therapy beyond these guidelines. In addition, the requested seven (7) units on each visit exceed the usual and customary 3-4 units of therapy on each visit. Finally, there is no allowance in the guidelines for aquatic therapy to be utilized in the rehabilitation of wrists and/or elbow injuries.

In conclusion, this request is not usual, customary, reasonable or medically necessary for the treatment of this patient's job-related injury.

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.
__X __Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __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.)