

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 12/12/07

**IRO CASE #:**

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

JAS Dynamic Static Progressive Splint

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Board Certified in Orthopedic Surgery, fellowship-trained in Hand and Upper Extremity Surgery

**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)

**INFORMATION PROVIDED FOR REVIEW:**

1. Records from the treating physician including a prescription for a JAS Static Progressive Splint to be used for one to two months by the treating physician
2. Office notes from Dr., surgeon, ranging from 11/29/07 as the last note and the first one
3. Office report dated 09/26/07
4. Fluoroscopy pictures
5. Prescription for physical therapy dated 11/20/07
6. Daily therapy notes ranging from 11/15/07 for the last one to the first one of 10/08/07
7. Form from JAS, which appears to be a demographic form
8. Range of motion and strength evaluation, which is part of the physical therapy notes
9. Prescription therapy prescription dated 10/02/07

10. Two insurance company Utilization Review denials for the splint, one dated 10/23/07 and the second dated 11/02/07, including ODG criteria utilized in the denial.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient suffered bilateral distal radius fracture requiring operative repair. The patient did well with regards to range of motion and return of function on the right side. However, the left side was restricted with regards to return to range of motion. This was documented in the physical therapy notes. The treating surgeon, therefore, recommended a static progressive splint manufactured by the JAS System for usage of one to two months.

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

A static progressive splint is effective in ankylosed joints, particularly with postoperative wrist fractures such as this one. The indications for this device have been met, and the second insurance company denial was really only because the reviewing physician did not have a copy of the prescription. This has been provided in the materials for my review. Therefore, I feel that the denial decision should be overturned, and the device should be approved for the patient to allow return to function and range of motion.

**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.

**INDEPENDENT REVIEW INCORPORATED**

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- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature: The Journal of Hand Surgery and Green's Operative Hand Surgery.
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)