



REVIEWER'S REPORT

DATE OF REVIEW: 9/6/2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 times per week for 4 weeks

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

Medical Doctor, board certified in orthopedic surgery

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. TDI Referral, August 17, 2007
2. ODG Guidelines for Acute and Chronic Carpal Tunnel Syndrome
3. Attorney's summary, August 22, 2007
4. Medical Clinic notes, October 25, 2005 to November 29, 2005
5. MD, office notes, December 19, 2005 to December 8, 2006
6. Workskills, office notes, December 16, 2005 to December 21, 2005
7. office notes, January 31, 2006 to May 18, 2007
8. DC, office notes, May 2, 2006 to May 24, 2006
9. MD, office notes, February 20, 2007 to July 10, 2007
10. Hospital surgical notes, March 22, 2007
11. DO, peer review, June 14, 2006

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This female suffered a rash of the right hand secondary to chemical exposure. She was treated appropriately and this rash resolved. Within 2 weeks she began complaining of right wrist pain, tingling, and numbness. Over the next 15 months she was treated for a number of diagnoses including DeQuervain's tenosynovitis, carpal tunnel syndrome and pronator tunnel syndrome. She was treated with a number of sessions of physical therapy. Carpal tunnel release and pronator tunnel release was performed 03/22/2007. She has received physical therapy sessions subsequent to the surgical procedure. She is now near 6 months after the surgery. Additional physical therapy consisting of paraffin bath, electrical stimulation, manual therapy, and therapeutic exercise has been requested.

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

This patient is beyond the period of time that the requested physical therapy in the immediate post operative period should be considered. ODG recommends "...3-8 visits over 3-5 weeks..." in the immediate post operative period after CTR. There are no clinical indications that this patient would benefit from further physical therapy of this nature at this point in time.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

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