

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 04/22/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient Occupational Therapy 3 times a week for 3 weeks

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

M.D., Board Certified Orthopedic Surgeon

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)

Upon independent review the reviewer finds that the requested Outpatient Occupational Therapy, 3 times a week for 3 weeks, is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Adverse Determination letters, 03/24/08, 03/31/08
2. ODG Guidelines and Treatment Guidelines
3. Hand/Upper Extremity Evaluation, 03/24/08
4. Evaluations 03/12/08, 03/04/08, 12/10/07, 10/02/07
5. Therapy Referrals 03/12/08
6. Employer's Report of Injury xx/xx/xx
7. Work Status Report 03/12/08, 03/04/08, 02/21/08, 02/12/08, 01/30/08

8. Duty Status 03/04/08, 02/21/08, 02/16/08, 01/30/08
9. Follow-up Visits 03/04/08, 02/12/08, 01/30/08, 02/16/08
10. Electrodiagnostic Medicine Results Report 02/21/08
11. Nerve Conduction Study 02/21/08
12. Physical Therapy Evaluation Form 01/31/08
13. Physical Therapy Daily Notes 01/31/08, 02/12/08, 02/04/08, 02/01/08, 02/08/08, 02/06/08
14. Previous Adverse Determination Letters 03/07/08, 02/13/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx-year-old injured worker who presents with right wrist and forearm discomfort and pain that radiates to the right shoulder. She states that she does repetitive type activities and has discomfort in the right hand with occasional numbness. The treating physician has requested outpatient occupational therapy for 3 times a week for 3 weeks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

It is the opinion of the treating physician that based upon the information submitted, that this injured worker has suffered repetitive motion impairment to the wrist. A previous diagnosis of carpal tunnel syndrome and de Quervain's tenosynovitis has been made and certain care has been offered, including six prior sessions of physical therapy. There has been no evidence of noted improvement in function and symptoms. Other treatments, such as injections of the wrist, did not help her, either. Based upon the ODG criteria for occupational therapy, with these current diagnoses, and past progress with therapy, this patient does not meet the criteria for occupational therapy treatments. It is fundamental within the ODG guidelines for occupational therapy for these diagnostic conditions that as time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of the frequency of treatment. It is also noted that the patient should be formally assessed after six visits of clinical trial to see if the patient is moving in a positive direction, no direction, or negative direction. Hence, in this particular case, where there has been no improvement, the patient is certainly not moving in a positive direction with the treatment that had already been offered. For this reason, the previous adverse determination is upheld.

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