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Notice of Independent Review Decision

DATE OF REVIEW: March 4, 2008

IRO CASE #:

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

This case was reviewed by a chiropractor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy, 3 x wk 6 wks

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o January 10, 2008 designated doctor evaluation report by M.D.
- o December 28, 2007 peer review report
- o January 23, 2008 peer review report
- o Undated provider list
- o April 20, 2005 through January 15, 2008 treatment history

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury. According to a January 10, 2008 designated doctor report, the patient is a male. The report states that since December 12, 2006, he was seen by a plastic surgeon and stated that he had severe muscle wasting in the left upper extremity due to a delay in medical treatment. As a result, he was taken to surgery on May 10, 2007. The postoperative diagnosis was severe compression of the radial nerve and ulnar nerve. The procedure was released left radial nerve, left cubital tunnel with subcutaneous transposition ulnar nerve. Postoperatively, the patient reported no relief of his symptoms and developed worsening weakness of the left hand. He was taken back to surgery on September 13, 2007. The postoperative diagnosis was painful neuroma in the radial nerve with entrapment of the left median nerve. The procedure was released left ulnar nerve with carpal tunnel release and excision of neuroma in the radial nerve. Postoperatively, pathology confirmed neuroma of the radial nerve. He reportedly had no improvement of his symptoms and had minimal therapy. The patient stated that his surgeon is requesting a third surgery.

Current complaints per the designated doctor report include weakness with deformity of the left hand, left knee pain with decreased range of motion, and decreased range of motion of the right ring finger. He achieved statutory MMI on January 9, 2008. The designated doctor stated that the patient should undergo a second opinion via an orthopedic surgeon with fellowship

training in upper extremity prior to any further surgery on the left upper extremity.

A December 18, 2007 chart note states that the patient did not notice any improvement in the claw hand deformity and his left hand is "nearly useless." The notes state that the patient has a prominent claw deformity of the left hand and the interosseous muscles are not regaining bulk. Enlargement of fluid collection on the radial-dorsal left wrist was also noted. A recommendation was made for the patient to continue physical therapy and for consideration of tapping the fluid collection on the next visit. Medical records from January 15, 2008 state that the patient feels worse with increased clawing of the left hand and weakness. Notes from February 12, 2008 state that the patient's left-hand clawing continues to worsen.

The records contain a December 28, 2007 peer review report for a request of 18 sessions of physical therapy. The report notes that the injured worker has had approximately 42 sessions of physical therapy to date. The request was non-certified and the Official Disability Guidelines quoted stating that 20 visits postoperatively for ulnar entrapment/cubital tunnel are appropriate. The report notes that the patient has exceeded that quantity and while it is noted that he feels better, there is no functional improvement. The request was again non-certified on January 23, 2008 by another physician reviewer. This report also quotes the Official Disability Guidelines. The report states that the patient has completed 42 sessions of physical therapy to date without evidence of progress or objective improvement.

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

In reviewing the treatment history list, the patient has completed 18 visits of physical therapy since the last surgery on September 13, 2007. Surgery reportedly consisted of release of the left ulnar nerve and carpal tunnel release with excision of a neuroma in the radial nerve. As noted below, the Official Disability Guidelines recommend 20 post-surgical treatments for ulnar nerve entrapment/cubital tunnel syndrome and three to eight visits for post-surgical treatment following carpal tunnel release. The injured worker has completed two visits fewer than the recommended quantity for ulnar nerve entrapment/cubital tunnel syndrome. However, the medical records fail to document clear functional objective improvement over the course of the post-operative physical therapy. In fact, the patient has been steadily worsening and a second surgical opinion has been recommended by the designated doctor. Without objective functional improvement resulting from the post-operative physical therapy and in light of the patient's worsening symptoms regarding the left upper extremity, continuation of physical therapy is not indicated. Therefore, my determination is to uphold the previous decisions to non-certify the request for physical therapy, three times per week for six weeks.

The IRO's decision is consistent with the following guidelines:

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
- ____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 NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

_____OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines (2008):

Physical/Occupational therapy:

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ($p < 0.05$). (Rapoliene, 2006)

ODG Physical/Occupational Therapy Guidelines -

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Fracture of carpal bone (wrist) (ICD9 814):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of metacarpal bone (hand) (ICD9 815):

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

Fracture of radius/ulna (forearm) (ICD9 813):

Post-surgical treatment: 16 visits over 8 weeks

Dislocation of wrist (ICD9 833):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

Dislocation of finger (ICD9 834):

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

Trigger finger (ICD9 727.03):

Post-surgical treatment: 9 visits over 8 weeks

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Synovitis and tenosynovitis (ICD9 727.0):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Mallet finger (ICD9 736.1)

16 visits over 8 weeks

Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):

Post-surgical treatment: 12 visits over 8 weeks

Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):

Post-surgical treatment: 18 visits over 6 weeks

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Sprains and strains of wrist and hand (ICD9 842):

9 visits over 8 weeks

Open wound of finger or hand (ICD9 883):

9 visits over 8 weeks. See also Early mobilization (for tendon injuries).

Pain in joint (ICD9 719.4):
9 visits over 8 weeks
Arthropathy, unspecified (ICD9 716.9):
Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks
Amputation of thumb; finger (ICD9 885; 886):
Post-replantation surgery: 36 visits over 12 weeks
Amputation of hand (ICD9 887):
Post-replantation surgery: 48 visits over 26 weeks
Work conditioning (See also Procedure Summary entry):
12 visits over 8 weeks

Official Disability Guidelines (2008):

Physical therapy (PT)

Recommended as indicated below. There is limited evidence demonstrating the effectiveness of PT or OT for CTS. The evidence may justify one pre-surgical visit for education and a home management program, or 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal tunnel syndrome should not result in extended time off work while undergoing multiple physical therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple physical therapy office visits for recovery. Of course, these statements do not apply to cases of failed surgery and/or misdiagnosis (e.g., CRPS I instead of CTS). (Feuerstein, 1999) (O'Conner-Cochrane, 2003) (Verhagen-Cochrane, 2004) (APTA, 2006) (Bilic, 2006) Post surgery a home physical therapy program is superior to extended splinting. (Cook, 1995) Continued visits should be contingent on documentation of objective improvement, i.e., VAS improvement greater than four, and long-term resolution of symptoms. Therapy should include education in a home program, work discussion and suggestions for modifications, lifestyle changes, and setting realistic expectations. Passive modalities, such as heat, iontophoresis, phonophoresis, ultrasound and electrical stimulation, should be minimized in favor of active treatments. See also more specific physical therapy modalities.

ODG Physical Therapy Guidelines -

Allow for fading of treatment frequency, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Carpal tunnel syndrome (ICD9 354.0):

Medical treatment: 1-3 visits over 3-5 weeks
Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks
Post-surgical treatment (open): 3-8 visits over 3-5 weeks