



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 5/19/2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Physical Therapy for the left and right hand/wrist 3 x Wk x 4 Wks (97010, 97035, 97140, 97124, and 97110).

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

The reviewer is a medical doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of Physical Therapy for the left and right hand/wrist 3 x Wk x 4 Wks (97010, 97035, 97140, 97124, and 97110).

A copy of the ODG was not provided for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured due to repetitive motion activities at work. She has undergone NCS (performed by a nurse and interpreted by a physician). She underwent CTR bilaterally, right (6/28/07) prior to left (5/31/07). This was followed by OT post-operatively. OT notes indicate that 15 encounters were performed from 6/15/07 to 7/18/07. Pt notes from Clinic indicate 1 PT encounter from 2/11/08. Dr. started gabapentin 900mg po qd and requested more PT on 11/28/07. Dr. requests 12 visits of PT over 4 weeks. This has been denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. The reviewer states that according to the ODG, Pt for CTS is

recommended, yet the number of visits is limited as follows. "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.

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"

As the patient has exceeded the number of recommended visits per the ODG, therefore the requested services are not medically necessary.

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)**