



DATE OF REVIEW: 05/09/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational therapy.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine and Rehabilitation, Pain Management

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:

I reviewed extensive medical records on the above individual, which I will summarize below:

1. I reviewed a Texas Worker’s Compensation Work Status Report. The signature on this is illegible.
2. I reviewed an emergency room note. There is no evident date on the record. The injured employee received a dog bite to the left hand and right hands.
3. I reviewed records from “The Doctor’s In” dated 03/16/07.
4. I reviewed a 03/30/07 note from The Doctor’s In. She was doing better with regards to the puncture wounds on her hands.
5. I reviewed an MRI report of the left wrist from Dr. dated 04/06/07, which showed “ganglion cyst, volar lateral surface adjacent to the radial ulnar joint space.” MRI scan of the left hand showed “normal MRI scan of the left hand as described.” This was also signed by Dr. on 04/06/07.
6. I reviewed notes from the Orthopedic Surgery Group dated 04/12/07.
7. I reviewed a note from the same clinic on 04/17/07. At that time she was found to have decreased muscle strength and range of motion, limiting her activities of daily living. It was recommended she have some occupational therapy at the time.

8. She received occupational therapy on 04/17/07.
9. She was seen by Dr. at the Orthopedic Group on 07/11/07. He was concerned about a possible injury to the ulnar nerve or artery on the left side and recommended electrodiagnostic study.
10. I reviewed a note from Dr. dated 07/30/07. This was a Designated Doctor Evaluation. It was felt she reached MMI on 07/30/07 and had a 0% impairment rating.
11. She was seen by Dr. on 08/24/07. He did not believe she was at maximum medical improvement.
12. On 09/07/07 Dr. reports her EMG study was “normal” in the left upper extremity.
13. The injured employee was seen by Dr. through the Orthopedic Group on 12/17/07 for pain management assessment. It was felt she had CRPS I.
14. She had an Independent Medical Examination on 03/13/08 by Dr.. He did not find evidence of radiculopathy or RSD or complex regional pain syndrome. He felt she had a combination of extensor tenosynovitis on the dorsal of the forearm as well as evidence of a flexor carpi ulnaris syndrome on the volar aspect. He recommended a steroid injection with two weeks of physical therapy, and if that failed, a tenolysis of both areas might be indicated.
15. She saw Dr. on 03/31/08. The symptoms of her right hand had fully resolved, but her left hand not. He injected her left wrist on 03/31/08, which improved her pain.
16. She had occupational therapy beginning 04/07/08.
17. I reviewed a report dated 05/14/08 from Dr. who did not believe further physical therapy was necessary.
18. I reviewed a 04/21/08 report from Dr. who did not believe additional therapy was necessary.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a xx-year-old female who sustained dog bite injuries to both hands at work on xx/xx/xx. She went on to have extensive occupational therapy. She had a negative MRI scan of the left hand. She had an MRI scan of the left wrist showing a ganglion cyst. She had a negative EMG study of the left wrist. Her right hand symptoms resolved, but her left hand symptoms persisted. She had an Independent Medical Examination, finding her to be at MMI with no impairment rating. She went on to have a Designated Doctor Evaluation with the finding of flexor and extensor tenosynovitis for which corticosteroid injection was recommended and implemented. It was then recommended that she have additional therapy.

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

The injured employee has been found to be at maximum medical improvement and has been exposed to extensive physical therapy above and beyond that which was recommended by the ODG Guidelines. She does not have radiculopathy, neuropathy, or complex regional pain syndrome. As she is at maximum medical improvement and has already received occupational therapy in excess of the ODG Guidelines, no additional therapy is recommended.

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 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.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)