

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 04/14/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3xWk x 4Wks Right Hand 97140, 97110, 97035, 98943

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

The TMF physician reviewer is a licensed chiropractor with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the physical therapy 3xWk x 4Wks right hand 97140, 97110, 97035, 98943 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting review by an IRO – 03/27/09
- Notice of Determination from – 02/17/09, 02/27/09
- Office visit notes by Dr. – 01/27/09

- Request for preauthorization – no date
- Initial evaluation by Dr. – 01/07/09
- Report of MRI of the right wrist and right hand – 01/26/09
- Resubmission of request for preauthorization – no date
- Occupational therapy evaluation – 04/30/08
- Occupational therapy reassessment and progress report – 06/05/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when she was cutting meat and began to feel intense pain and swelling in her right hand and wrist. An MRI of the right hand and wrist revealed small cystic changes in the navicular and capitate without acute characteristics. The conclusion was an otherwise normal MRI of the right wrist. Specifically, there was no evidence of tenosynovitis in the wrist. MRI of the right hand indicated a normal MRI of the right hand. The patient was treated with 5 visits of occupational therapy.

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

This patient was evaluation by a physician on 01/07/09 who states that the wrist pain is virtually the same on that day as it was when the pain began, some 10 months later. An assessment of stenosing tenosynovitis (De Quervain's disease) was made. After this evaluation on 01/07/09 a MRI of the right hand and wrist were ordered and performed. The MRI of the right hand and wrist revealed small cystic changes in the navicular and captate without acute characteristics. The conclusion was an otherwise normal MRI of the wrist. Specifically, there was no evidence of tenosynovitis in the wrist. MRI of the right hand indicated normal MRI of the right hand. On the follow up visit on 01/27.09, there appeared to some objective findings and the assessment was changed to status post repetitive motion disorder with resultant wrist tendonitis starting in the flexor and extensor muscles of the forearm, mainly the pronator teres and the extensor wad. The doctor requested 12 physical therapy visits to include wrist mobilization/manipulation, ultrasound, manual therapy with trigger point therapy and therapeutic exercises.

The medical record documentation indicates that the patient received appropriate treatment for her injury per ODG's and was released from care in August of 2008. It would be expected that the therapy she received included instructions in an appropriate home exercise program. For an injury of this nature, she has exceeded the allowable ODG's physical/occupation therapy within the given time period. Therefore, it is determined that the requested additional 12 physical therapy visits of 3 times per week for 4 weeks would not be appropriate.

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)