



Notice of Independent Review Decision
PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 4/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1. Outpatient physical therapy 3 times a week for 4 weeks

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from and completed training in Physical Med & Rehab at. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in .

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

1. Outpatient physical therapy 3 times a week for 4 weeks Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The worker is a female who reportedly sustained a trauma injury to her hands and wrists. Her diagnosis was noted to be 354.0 – Carpal Tunnel Syndrome. She has complaints of bilateral hand numbness since March 2008. Treatment included anti-inflammatory medication, physical medicine rehabilitation, and night splinting without significant improvement. She underwent a left carpal tunnel release on 12/8/2008. Physical therapy was recommended by her provider.

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

The worker is a female who reportedly sustained a trauma injury to her hands and wrists. Her diagnosis was noted to be Carpal Tunnel Syndrome. She has complaints of bilateral hand numbness since March 2008. The injured worker had EMG xx-xx-xx which confirmed diagnosis of carpal tunnel syndrome bilaterally. Treatment included anti-inflammatory medication, physical medicine rehabilitation, and night splinting without significant improvement. The injured worker underwent open carpal tunnel release and tenosynovectomy of the left wrist flexor tendon on 12/8/2008. She has done 12 post op therapy sessions to date. Request for 12 more sessions physical therapy submitted. Subsequent requests were denied. Then, on 3/6/2009 Dr. states "I think the independent reviewer is denying her physical medicine rehabilitation based on the guidelines for carpal tunnel release. The patient has flexor tendon synovectomy along with the carpal tunnel release and for that condition the patient need more extensive physical medicine program." ODG recommends 8 sessions of post op physical therapy for open carpal tunnel release and 14 sessions for post surgical treatment of synovitis/tenosynovitis. ODG also has the following caveat regarding treatment beyond guideline recommendations, "More visits may be necessary when grip strength is a problem, even if range of motion is improved." Per the therapy notes on 1/27/2009 which is the last day of service, the patient's range of motion has improved from the initial evaluation on 12/22/2008. Degree measures; wrist extension -12 to 40, flexion 12 to 41, ulnar deviation 19 to 14, radial deviation 2 to 8, forearm pronation 60 to 83 and supination -44 to

Name: Patient_Name

81. Grip strength has improved significantly with left being stronger than right.

At this point some additional therapy may indeed be indicated but to recommend 12 additional therapy sessions would be considered excessive in its request since the injured worker has only had 12 sessions post op. Additional therapy sessions beyond ODG recommendations would require additional medical rationale and careful follow-up to

Name: Patient_Name

insure progress and 3 times a week for 4 weeks would not allow for care follow-up, trouble shooting, and alteration of care plan if need be.

The recommendation is that previous denial be upheld as the request is not considered 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

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)