



**Amended March 19, 2009**

**DATE OF REVIEW:** 02/28/09

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Medical necessity of occupational therapy.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., Family Practice physician, board certified by the American Board of Family Practice, in private practice with the opportunity to treat many patients and evaluate many patients with the medical problems that are present in this case as well as to assess and evaluate the need for occupational therapy in patients for 25 years

**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:**

1. TDI Referral
2. URA findings, 1/29/09 to 2/13/09
3. Findings, 1/29/09 to 2/3/09
4. Orthopedic Group office notes, 1/19/2/09 to 1/19/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The patient has no significant medical history but complains of having injured the right forearm, left forearm, right wrist, and left wrist while performing competitive motion at work. The patient has had eleven previous occupational therapy sessions as well as MRI scans showing medial and lateral epicondylitis and other testing revealing bilateral carpal tunnel syndrome. The patient continues to have pain.

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

The patient has previously had eleven occupational therapy visits. Further OT care will be extremely unlikely to offer further benefits. The modalities requested are either of limited, short term, or unproven efficacy. Specifically, iontophoresis has short term but no significant long term data showing long term benefit. The stimulation has insufficient evidence. Further occupational therapy modalities will likely produce no further benefit despite that already obtained.

**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.)