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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 3Wks 97110 97140

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates:

Forearm/Wrist/Hand – Physical therapy

Dr. Office Records: 05/04/10, 06/01/10, 06/22/10, 07/20/10

Physical Therapy Treatment Notes: 05/18/10 through 06/24/10 time nine visits

Physical Therapy Progress Report: 05/28/10

Prescription for continued physical therapy: 06/01/10

, Peer Reviews, 07/01/10, 07/16/10

PATIENT CLINICAL HISTORY SUMMARY

This is a female claimant with a reported right wrist injury that occurred while at work on xx/xx/xx from repetitive use when she developed pain, swelling and redness in the volar aspect of her right wrist. The diagnosis is right wrist ganglion and tendinitis. Examination findings revealed a volar ganglion overlying the flexor carpi ulnaris tendon of the right wrist with pain, swelling and tenderness across the volar aspect of wrist along flexor carpi radialis and ulnaris tendons. Conservative management included a compression wrist band with Flector patch, exercise and strength training, activity modifications, modified work duty, bracing, medications and physical therapy. No abnormalities were revealed on the 06/01/10 x-rays. The 07/20/10 office record revealed the claimant was four and a half months pregnant with continued persistent pain and discomfort within the right wrist. The exam revealed tenderness obscurely across the volar and dorsal aspects of the right wrist with pain radiating toward the extensor musculature at the elbow. Dr. requested authorization for continued physical therapy to recondition and strengthen her wrist and arm in an attempt to alleviate her painful symptomatology.

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

The requested physical therapy sessions three times a week for three weeks cannot be considered medically necessary. The claimant was diagnosed with right wrist tendinitis and right ganglion cyst. She was treated conservatively with activity modifications, restricted work

duties, bracing and physical therapy with noted but temporary improvement. ODG guidelines allow for 9 physical therapy sessions for tenosynovitis.

The claimant completed 9 physical therapy sessions from 05/18/10 through 06/24/10 and based on those sessions should be independent in her home exercise program at this point in time. It is unclear what benefit would be obtained from additional formal therapy that could not be obtained with continued conservative measures that include her home exercise program. Based on the reviewed records and the ODG, the reviewer finds that medical necessity does not exist for Physical Therapy 3xWk x 3Wks 97110 97140.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates:
Forearm/Wrist/Hand – Physical therapy

ODG Physical Therapy Guidelines: Allow for fading of treatment frequency plus active self-directed home PT.

- Synovitis and tenosynovitis: Medical treatment: 9 visits over 8 weeks

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)