

SENT VIA EMAIL OR FAX ON
Jan/04/2010

True Decisions Inc.

An Independent Review Organization
835 E. Lamar Blvd. #394
Arlington, TX 76011
Phone: (214) 717-4260
Fax: (214) 594-8608
Email: rm@truedecisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Dec/28/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 Physical Therapy Visits

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

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

OD Guidelines

Denial Letters 12/4/09 and 11/27/09

10/27/09 thru 12/11/09

OP Report 9/25/09

10/15/09 and 10/22/09

PATIENT CLINICAL HISTORY SUMMARY

This is a man injured in x/xx. He had surgery in 2007, but the type of procedure was not provided. He had ongoing symptoms and underwent DeQuervain decompression/release on 8/28/09 followed by a Carpal tunnel releases on 9/25/09. The Reviewer could not determine why the delay in the CTS release. The Reviewer does not know when the symptoms worsened, but the presence of reported thenar atrophy suggested a chronic condition the Surgical report by Dr. described marked compression of the median nerve by a "dense carpal tunnel ligament." Her performed an internal neurolysis and tenosynovectomy. The 10/22/09 note described improved symptoms, strength and range of motion. He was in a home program at that time. He had therapy after the 8/09 procedure.

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

The ODG recognizes the appropriateness for up to 8 sessions of PT (OT) over 3-5 weeks. This is compatible with the 8 sessions over 4 weeks requested. The chronicity of the situation based upon the thenar atrophy and the description of the compressed nerve, plus the recent DeQuervain surgery suggest a need for the upper permitted limits of treatment, even with the prior hand therapy. At the same time, he did well without formal treatment per Dr. Therefore, after a careful review of all medical records, the Reviewers medical assessment is that the request is medically necessary.

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)