



Notice of Independent Review Decision

DATE OF REVIEW: 06/07/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional Occupational Therapy Left Wrist 3 x Week/3 Weeks
Paraffin Bath Therapy Left Wrist 3 x Week/3 Weeks
Therapeutic Activities Left Wrist 3 x Week/3 Weeks
Manual Therapy Left Wrist 3 x Week/3 Weeks
Electrical Stimulation Left Wrist 3 x Week/3 Weeks
Occupational Therapy Re-Evaluation Left Wrist

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand 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)

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.

Additional Occupational Therapy Left Wrist 3 x Week/3 Weeks – UPHELD
Paraffin Bath Therapy Left Wrist 3 x Week/3 Weeks – UPHELD Therapeutic
Activities Left Wrist 3 x Week/3 Weeks – UPHELD
Manual Therapy Left Wrist 3 x Week/3 Weeks – UPHELD
Electrical Stimulation Left Wrist 3 x Week/3 Weeks – UPHELD
Occupational Therapy Re-Evaluation Left Wrist - UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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PATIENT CLINICAL HISTORY (SUMMARY):

The patient sprained his left wrist when he unloaded a trailer, pushing and pulling a pallet. He underwent conservative therapy including Motrin 800 mg and Ketoprofen 4% cream and physical therapy. An MRI showed osteoarthritis with marked joint space narrowing and subcortical cyst formation. A tear was also suspected at the TFCC at the level of the ulnar attachment. The patient later underwent an open release of the left wrist carpal tunnel, followed by additional physical therapy. An FCE performed showed he was demonstrating an inability to return to full work duty as a stocker for Wal-Mart. He was referred for work hardening at that time.

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

The requested additional therapy is not medically reasonable nor necessary. I agree with the earlier determination in that this patient has received an adequate amount of therapy postoperatively from a carpal tunnel release. The patient falls outside ODG recommendations for normal post-operative treatment of carpal tunnel syndrome. I see no evidence in the chart to adequately support further therapy with regard to this patient's diagnosis and thus, I do not believe that the current treatment is reasonable and 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**
- 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)**