

SENT VIA EMAIL OR FAX ON  
Jul/12/2010

## Applied Assessments LLC

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Jul/12/2010

**IRO CASE #:**

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

10 sessions of CPMP, 80 hours

**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 6/4/10, 6/14/10, 6/16/10

PT 5/26/10 thru 6/28/10

Injury 4/6/10

OP Report 3/16/09

Dr. 2/6/09

Imaging Center 2/3/09

MRI 7/24/08

FCE 2/24/10

6/4/10 and 6/16/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman who reportedly was injured on xx/xx/xx. She reportedly xxx for about 10 days and developed right shoulder and arm pain. The job description in the FCE including

lifting and carrying boxes. The CT scan, not provided, reportedly showed nerve damage. The MRI reportedly showed loose bones and ligaments. The report (7/24/08) showed suggestions of scapholunate instability and no evidence of injury/sprain to the associated ligaments. There was a central tear of the ulnar triangular fibrocartilage, not at the site of her symptoms. She had electrodiagnostic studies that were interpreted as bilateral CTS with unilateral symptoms. She failed to improve with 8 months of therapy, per Dr.. He performed a carpal tunnel release on 3/16/09 and he described synovial hypertrophy. She failed to improve. Dr. felt she had causalgia. He wanted sympathetic injections that were not approved. She had an FCE on 2/24/10. She failed to improve with work conditioning. Dr. noted her right grasp as 0 Kg and up to 1 kg of pinch on 4/9/10. A pain program was advised.

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

She had been working a short time when symptoms started. The IRO reviewer is not clear of the true pathology. The scapholunate instability is unlikely work related without any trauma, especially with intact ligaments. The CTS diagnosis was made by the NCV, which was positive bilaterally with unilateral symptoms. False positive electrodiagnostic studies exist. She did not improve with a work-conditioning program. Dr. stated that this was a single modality program and the psychological component was not provided. The ODG combines the work conditioning and work hardening programs with the pain programs as ones that should not be duplicated. Further, it places the choice of the appropriate program on the providers. Further, Dr. notes her "resistant to recognizing the effect of psychological issues on her pain." She has neck and right upper extremity symptoms, and the ODG has reservations about cervical and upper shoulder pain programs. With all the above factors, the request is not 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)