

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 2/19/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OT 3X4 weeks wrist left A/PROM
97110, 97140, G0283, 97112, 97035

QUALIFICATIONS OF THE REVIEWER:

This reviewer completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

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)

OT 3X4 weeks wrist left A/PROM
97110, 97140, G0283, 97112, 97035 Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Review of case assignment dated 02/01/2010
2. Notice to utilization review dated 02/01/2010
3. IRO request form by author unknown dated 01/29/2010
4. Request form by author unknown dated 01/27/2010
5. Clinical note by RN dated 01/21/2010
6. Fax page dated 01/15/2010
7. History note by MD dated 01/13/2010
8. Clinical note by RN dated 01/12/2010
9. Fax page dated 01/11/2010
10. Letter by dated 01/11/2010
11. Clinical note by RN dated 01/06/2010
12. OT request by author unknown dated 01/04/2010
13. Evaluate and treat by author unknown dated 01/04/2010
14. Progress note by OTR dated 12/31/2009
15. History note by PA-C dated 12/18/2009
16. Progress note by author unknown dated 12/18/2009 and 01/13/2010
17. The ODG Guidelines were not provided

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a female who injured the left wrist with fracture on xx/xx/xx. Injured employee is status post ORIF to left wrist. A request for OT 3 times per week for 4 weeks is submitted. Injured employee has had at least 40 visits of 42 authorized PT/OT since 9/14/09. OT was initiated on 12/17/09 for 7 total sessions after completion of PT. Per notes on 12/31/09 the injured employee is pain free but pain comes back when it gets cold and has difficulty opening packages and has numbness in the radial portion of the hand. Injured employee's pain can be at worst 7/10. Injured employee continues to have decreased range of motion in the wrist and tenderness about the left wrist and hand. The injured employee has mild limitation with typing. Note by Dr. on 1/13/10 states she has some probable inflammation of the median and radial nerves possibly from aggressive stretching. Consideration of

hardware removal or carpal tunnel release could be considered in the future but he recommends giving it more time to potentially resolve. A pain specialist consult is recommended to evaluate for possible RSD. He recommends continued stretching and Dynasplint and follow-up in 2 months.

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

The injured employee has had 42 approved visits of therapy to date with overall improvement in strength, range of motion and decreased pain as documented. Injured employee continues to have some subjective symptoms and limitations as noted by the therapy and Dr. Dr. recommends continued splint use and stretching program. The need for continued therapy is unclear and not addressed by the treating physician. At this point and according to ODG recommendations the injured employee has had an ample amount of supervised therapy, beyond standard ODG recommendations, and is appropriate for discharge to independent home exercise program and continued follow up with treating physician as scheduled. The recommendation is that the prior 2 denials for continued therapy be upheld.

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)