

SENT VIA EMAIL OR FAX ON
May/05/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational Therapy 5 X wk X 2 wks for the left hand s/p surgery

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

Board Certified in Orthopaedic Surgery
Fellowship Training in Upper Extremities

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 4/2/10 and 2/15/10
Health 1/12/10 thru 4/5/10
Dr. 1/14/10 thru 3/26/10
Dr. 3/12/10

PATIENT CLINICAL HISTORY SUMMARY

The patient has mild to moderate bilateral carpal tunnel syndrome after a severe open injury to the left thumb, index and middle finger. EMG confirms median nerve compression. The patient has received extensive postoperative rehab after the hand injury. The patient has not responded well to conservative care for CTS including an injection into the carpal canal.

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

The patient has failed conservative care for carpal tunnel syndrome related to the hand injury. The patient appears to be a surgical candidate for carpal tunnel release, therefore making the request for more OT not medically reasonable or appropriate at this time, as recommend by the guidelines.

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 KNOWLEDGBASE

- 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)
- OKU SPINE
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)