



Southwestern Forensic
Associates, Inc.

Amended October 21, 2010

REVIEWER'S REPORT

DATE OF REVIEW: 10/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional physical therapy/occupational therapy three times per week for seven weeks, utilizing CPT codes 97110 (Additional OT), 97010(Hot or Cold Pack), 97018 (Paraffin Bath, 97039 (PT Treatment), 97035 (Ultrasound), and 97140 (Manual Therapy).

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering hand injuries and chronic complex regional pain syndrome.

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. Forensic forms
2. TDI referral forms
3. Certification of independence of the reviewer
4. denial letters
5. Adverse determination letter
6. Preauthorization/concurrent review request
7. PT/OT prescriptions dated 09/07/10 and 09/16/10
8. Clinical notes, 20 clinical notes between 09/16/09 and 10/05/09, M.D.
9. Request reconsideration

10. Requestor records
11. Occupational therapy notes, 62 sessions of occupational therapy between 10/12/09 and 06/23/10
12. History and physical examination 06/18/10
13. Operative report 06/18/10, left stellate ganglion block
14. Clinical notes, M.D. and M.D., 05/27/10 and 05/21/10
15. Lab data 05/25/10
16. Operative report 03/18/10, capsular release, PIP joint, index finger, left hand
17. Physician records TWCC-69 form 09/03/10, M.D., Designated Doctor report, M.D.

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The injured employee is a male who suffered a crush injury and laceration to the index finger of the left hand on xx/xx/xx. He underwent a debridement and repair on 08/14/09. Subsequently, he developed stiffness and a chronic regional pain syndrome which has required multiple medications, stellate ganglion block, and as many as 62 sessions of physical therapy and occupational therapy. He continues to suffer stiffness and chronic pain. The current request is for additional physical therapy. The request for additional physical therapy has been considered and denied. It was reconsidered and denied.

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

This individual has had a very extensive regimen of physical therapy and occupational therapy to a total of approximately 62 sessions. He does demonstrate periodic improvement; however, he continues to recur with stiffness and chronic complex regional pain syndrome. It would appear that he has achieved as much benefit from a supervised physical therapy/occupational therapy program as can possibly be achieved. Additional physical therapy or occupational therapy would have little likelihood of being successful where previous regimens have failed. The prior denials were appropriate and should be upheld.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- _____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.
- ___X___ Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
- _____Mercy Center Consensus Conference Guidelines.
- _____Milliman Care Guidelines.
- ___X___ ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Cervical Spine Chapter, Discography passage.

- _____ Pressley Reed, The Medical Disability Advisor.
- _____ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- _____ Texas TACADA Guidelines.
- _____ TMF Screening Criteria Manual.
- _____ Peer reviewed national accepted medical literature (provide a description).
- _____ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)