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NOTICE OF AMENDED INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/28/2010

DATE OF AMENDED REVIEW:

Aug/30/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 x 4 R wrist 97110 G0283 97124 97535

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

M.D., Board Certified Orthopedic Surgeon

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

Dr. office visit 03/23/09

MRI right wrist 04/23/09

Dr. office note 06/29/09

Dr. rehab evaluation 06/22/10

Dr. office note 06/29/10, 07/29/10, 08/03/10

Dr. prescription 06/29/10

Peer review 07/07/10, 07/23/10

Dr. letter 07/13/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female apparently with a right upper extremity injury on xx/xx/xx. The claimant underwent right shoulder rotator cuff repair on 08/29/07 and right DeQuervain's release on 07/30/08. EMG/NCS on 11/13/08 was a normal study. On 03/23/09 the claimant saw Dr. in follow up for right wrist pain that radiated to the shoulder. She was taking Naproxen and working with restrictions. X-rays of the right wrist showed radiocarpal osteoarthritis. MRI of the right wrist on 04/23/09 showed suggestion of deformity with poorly defined intermediate signal within the substance of the TFCC most likely related to an old tear. There was minimal fluid collection within the tendon sheath of the extensor carpi radialis brevis and the extensor carpi radialis longus compatible with mild tenosynovitis. There was narrowing of the radiocarpal joint with subchondral sclerosis and a mild degree of ulnar minus variant. There was a small intraosseous ganglion within the lunate bone. The records lapse until June 2010 at which time the claimant presented to Dr., chiropractor, for therapy ordered by Dr.. On 06/22/10 Dr. documented increased pain in the right shoulder and right wrist with no new injury. Right shoulder flexion was 120 degrees, extension 20 degrees, internal rotation 40 degrees, external rotation 20 degrees, abduction 80 degrees and adduction 10 degrees with strong pain in all extremes of motion. Motor strength was 4/5. Right wrist flexion was 30 degrees, extension 30 degrees, ulnar deviation 15 degrees, and

radial deviation 10 degrees with pain in extremes of motion. Grip was weak on the right. Motor strength was 4/5. The claimant was taking Naprelan.

On 06/29/10 Dr. documented tenderness on palpation of the wrist. The diagnosis was sprained right supraspinatus tendon status post surgery; sprained right wrist and DeQuervain's tenosynovitis status post surgery. Dr. ordered physical therapy; the therapy was denied on peer review. Dr. authored an appeal letter dated 07/13/10 in which he noted that the claimant had returned to full duty as. In June 2010 she reported increased pain. Dr. felt that the claimant was suffering from a flare up of her tenosynovitis and shoulder tendonitis and felt that a short course of physical therapy in conjunction with medication was the best course of treatment to get her symptoms back under control. He noted that the claimant's post op therapy had been over two years ago and the current request for therapy was for a recent flare up.

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

In Dr. 's letter requesting physical therapy, he noted that the claimant had post operative rehabilitation following her surgical procedures and returned to full duty work as a. On 06/03/10 the claimant had increasing wrist and shoulder pain and it was felt she had a flare up of tenosynovitis and the physician recommended a short course of physical therapy. Based solely on the records provided and evidence based medicine, the reviewer finds that medical necessity does exist for PT 3 x 4 R wrist 97110 G0283 97124 97535. This is based on a recent flare up of reported tendonitis and appropriately treated with rest and anti-inflammatory medication. The claimant has decreased range of motion and weakness and would likely benefit from a course of therapy. The reviewer finds that medical necessity exists for PT 3 x 4 R wrist 97110 G0283 97124 97535.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates.

Forearm, hand, wrist: physical therapy.

ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04)

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Sprains and strains of wrist and hand (ICD9 842)

9 visits over 8 weeks

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)