

SENT VIA EMAIL OR FAX ON  
May/25/2012

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

May/24/2012

**IRO CASE #:**

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

Physical Therapy (3X2) X 6 sessions

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

PM&R and Pain Medicine

**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

Cover sheet and working documents

Utilization review determination dated 04/24/12, 05/10/12

Office visit note dated 02/23/12, 02/29/12, 03/16/12, 04/02/12, 04/18/12, 05/02/12, 05/10/12, 04/17/12

Physical therapy evaluation dated 03/07/12, 03/21/12, 04/05/12, 04/20/12, 05/03/12

Physical therapy daily notes dated 03/07/12, 03/09/12, 03/12/12, 03/14/12, 03/15/12, 03/19/12, 03/21/12, 03/26/12, 03/27/12, 03/29/12, 04/02/12, 04/03/12, 04/05/12, 04/09/12, 04/10/12, 04/12/12, 04/16/12, 04/17/12, 04/20/12, 04/23/12

Letter dated 05/02/12

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was catching a bowl that slipped out of her hands and sustained injury to her left hand/wrist. The patient was seen and diagnosed with tenosynovitis of the left hand and wrist. The patient

subsequently completed 20 sessions of physical therapy. Physical therapy evaluation dated 03/07/12 indicates that left wrist range of motion is flexion 45, extension 31, radial deviation 5 and ulnar deviation 10 degrees. Follow up evaluation dated 05/02/12 indicates that range of motion flexion remained the same, extension remained the same, ulnar deviation is full and radial deviation is full. Pronation is full. Letter dated 05/02/12 indicates that the patient has noted improvement in range of motion and strength, but has continued to have numbness and tingling in her thumb as well as tenderness to palpation.

Initial request for physical therapy x 6 sessions was non-certified on 04/24/12 noting that the patient has failed to progress with prior therapy. Given failure to progress with directed PT, for not transitioning to home exercise program at this time is unclear based on very limited attached data available for review. The denial was upheld on appeal dated 05/10/12 noting that the history and documentation do not objectively support the request for additional PT at this time. The claimant has attended what should have been a sufficient number of rehab visits to date for her injury and there is no evidence that she remains unable to continue and complete her rehab with an independent home exercise program. There is no indication that continuation of supervised exercises is likely to provide her with significant or sustained benefit that she cannot achieve on her own.

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

Based on the clinical information provided, the request for physical therapy (3x2) x 6 sessions is not recommended as medically necessary, and the two previous denials are upheld. The patient has been diagnosed with left hand and wrist tenosynovitis. The patient has completed 20 sessions of physical therapy to date. The Official Disability Guidelines support up to 9 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

#### **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)