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Notice of Independent Review Decision

Date notice sent to all parties: 9/19/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy request for right wrist up to 3 times per week for 2
Weeks

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

Texas Licensed physician with Board Certification in Orthopedic Surgery/Occupational
Medicine.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse
determination/adverse determinations should be:

X-Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical
necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Review includes:

1. Denial letter dated 7/10/12
2. Denial letter dated 7/30/12
3. Rebuttal letter dated 7/18/12, 6/27/12
4. PT notes 8/13/12 through 5/18/12
5. 8/9/12 and 8/3/12 therapy request
6. DWC-73 forms 8/3/10, 7/13/12, 6/22/12, 5/30/12, 5/18/12
7. Approval of therapy dated 6/18/12
8. Approval of MRI dated 6/6/12
9. MRI 6/6/12
10. Approval of therapy dated 6/1/12
11. Title 28 Insurance codes, Chapter 12, Subchapter A

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect that the claimant is a man with history of work injury xx/xx/xx. He reportedly injured his right wrist when he picked up a 50-pound counterweight and snapped his right wrist. He has been followed at Medical Centers by a number of clinicians. The claimant has been followed by Dr., Dr., Dr., and medical director Dr.. There are also notes by other clinicians Dr.. The available medical records reflect that the claimant has had chronic and persistent right hand and wrist pain complaints. Right hand and wrist x-rays were reportedly negative for fracture or dislocation. An MRI of the right wrist/hand was performed on June 6, 2012. Right wrist MRI was reviewed at Imaging by radiologist, Dr.. He notes that there were findings showing a small amount of joint fluid within the radiocarpal joint as within the distal radial ulnar joint. The distal radius and distal ulnar had normal signal. A small dorsal wrist ganglion overlaid the scapholunate articulation. There was also a small tear of the TFCC (triangular fibrocartilage complex) near its insertion on the radius. The TFCC insertion on the ulnar styloid was normal. The overall impression was a hyperintense median nerve, which could be seen with carpal tunnel syndrome, a tear of the TFCC near its insertion on the radius, and a small dorsal wrist ganglion measuring 5 mm

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

- . According to notes, the claimant has already received 15 post injury physical therapy sessions.

ODG guidelines address synovitis and tenosynovitis of the wrist as well as hand and wrist sprain/strain. Based on the information reviewed, the claimant has already received a sufficient course of physical therapy to address right hand and wrist complaints. One would expect as indicated in ODG guidelines of the forearm, wrist, and hand chapter, that the claimant would be fading the form of treatment to perform a self-supervised active home exercise program.

Unable to certify the medical necessity for outpatient physical therapy to right wrist three times a week for two weeks at this time. This is consistent with ODG guidelines of the forearm, wrist, and hand.

IRO REVIEWER REPORT TEMPLATE -WC

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

**X-DWC- DIVISION OF WORKERS COMPENSATION POLICIES
OR GUIDELINES**

**X-MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE
IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

**X-ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT
GUIDELINES**