

US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/13/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 2xWk x 8Wks for both hands/wrists

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Orthopedic Surgery

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the request for physical therapy 2xWk x 8Wks for both hands/wrists is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination dated 10/17/13, 08/29/13
Appeal letter dated 09/12/13
Electrodiagnostic study dated 08/23/13, 04/22/13
Physical therapy initial examination dated 07/15/13
Plan of care dated 03/27/13, 02/22/13, 12/14/12, 01/23/13
Carrier submission dated 10/28/12

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as repetitive motion. Per plan of care dated 02/22/13, diagnosis is carpal tunnel syndrome. The patient has completed 23 occupational therapy visits. Plan of care dated 03/27/13 indicates that the patient completed 10 additional OT visits. EMG/NCV dated 04/22/13 revealed evidence of a slight right carpal tunnel syndrome. Physical therapy initial examination dated 07/15/13 indicates that the patient was working full time. The patient feels like therapy helped some of the pain, but it was not lasting relief. On physical examination Tinel's is negative bilaterally. Phalen's is negative bilaterally. Right wrist range of motion is extension 70, flexion 55, radial deviation 20 and ulnar deviation 40 degrees. Left wrist range of motion is extension 80, flexion 60, radial deviation 30 and ulnar deviation 45 degrees. EMG/NCV dated 08/23/13 revealed no evidence of peripheral neuropathy, motor radiculopathy or myopathy. The testing is not able to exclude a sensory radiculopathy or radiculitis.

Initial request for physical therapy 2 x wk x 8 wks was non-certified on 08/29/13 noting that the Official Disability Guidelines state to allow for fading of treatment frequency plus an active self-directed home exercise program. The clinical notes reviewed indicate the patient has

participated in previous occupational therapy program; however, the number of sessions and its effectiveness is not stated. The most recent clinical note reviewed does not state significant objective findings of the patient's pain symptoms or functional deficits for the bilateral hands/wrists to support physical therapy. In addition, it does not state whether the patient has been participating in a hex and its efficacy. In addition, the requested 16 sessions exceeds guideline recommendations. The denial was upheld on appeal dated 10/17/13 noting that the patient has attended 31 occupational therapy visits. The Official Disability Guidelines recommend 9 visits of physical therapy over 8 weeks for pain in the joint. The patient's functional gains and remaining deficits after occupational therapy and physical therapy attended were not detailed within the provided medical records.

The guidelines recommend a formal assessment of the patient's condition to see if the patient is moving in a positive direction, no direction or a negative direction. The requesting physician did not include a formal assessment of the patient's condition after completing all sessions of occupational and physical therapy to show the patient's functional gains and remaining functional deficits in order to demonstrate the need for further physical therapy at this time. Additionally, the request for 16 additional sessions of physical therapy would exceed guideline recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient has completed at least 30 sessions of therapy to date. The Official Disability Guidelines support up to 9 sessions 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. Physical therapy initial examination dated 07/15/13 indicates that the patient was working full time. The patient feels like therapy helped some of the pain, but it was not lasting relief. 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. As such, it is the opinion of the reviewer that the request for physical therapy 2xWk x 8Wks for both hands/wrists is not recommended as medically necessary.

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)