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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: 10/22/13

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 3x/week for 3 weeks to the left hand.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3x/week for 3 weeks to the left hand.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed: 9/20/13 CCH report with exhibit listing, and witness list, 8/19/13 eval, 7/1/13 and 7/31/13 PT re-evaluation reports, 8/16/13 DWC 73 report, various statement of earnings, 8/29/13 BRC report with exhibit list, 5/17/13 handwritten report, 8/16/13 medical services referral form for PT, 5/2/13 to 8/16/13 reports, 8/16/13 medical report, 8/11/13 report, 7/8/13 PT approval letter, 3/18/13 to 5/17/13 DWC 73 forms, 10/1/13 CCH report with exhibits, 9/9/13

denial letter, 8/6/13 BRC report with exhibits, DWC 41 report, 7/3/13 PLN 11 report, 3/20/13 radiographic report, 2/11/13 report, 2/25/13 to 3/25/13 reports, 5/2/13 medication script, and 2/11/13 return to work.

9/18/13 denial letter, and 3/20/13 left wrist MRI.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has a date of birth of xx/xx/xx. He reported his wrist popped. The injury was reported xx/xx/xx. An MRI reveals some degenerative changes of the triangular fibrocartilage but no acute changes. He has had physical therapy with some improvements. He was initially prescribed 12 visits of PT. His diagnosis was a left wrist sprain. Additionally, the patient has hypertension and diabetes. Medications include Metformin, Norvasc, Amlodipine, Piroxicam, Benazepril, HCTZ, Naproxen, and Ultram. There is a request for additional therapy.

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

Physical therapy is recommended for a wrist sprain. 9 visits are recommended over 8 weeks. There should be evidence of improvement with therapy and a home exercise program for consideration of additional therapy. Therapy is provided with the goal of transition to an active self-directed home PT program. Additional PT is not supported by the medical records provided, or the ODG; therefore, it is not medically necessary at this time.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Medical treatment: 9 visits over 8 weeks

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

- 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
- 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)