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## Notice of Independent Review Decision

**DATE OF REVIEW:** 2/10/2015

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of eight sessions of physical therapy for the left wrist.

**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 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of eight sessions of physical therapy for the left wrist.

**PATIENT CLINICAL HISTORY [SUMMARY]:** : On the date of injury, the then patient was noted to have slipped and fallen with a resultant injury to the affected forearm/wrist. There was a diagnosis of persistent tenosynovitis that had been treated initially non-operatively and then surgically. The surgical procedure was performed at the end of June 2014. Postoperative treatments included medications and restricted activities, along with therapy and a cortisone injection. Treatments in December 2014 were noted to include another cortisone injection. Decreased wrist pain and hypersensitivity were reported on December 18, 2015. Exam findings were noted to have been "unchanged" from prior and work with restrictions was allowed for by the treating provider. On the

prior December 3, 2015, exam findings were noted to reveal motion being at 75% of normal, some generalized hypersensitivity and a positive Tinel over the sensory branch of the radial nerve. Denial letters discussed that the patient was at least six months postop and with an undocumented prior number of therapy sessions and outcome. It was also opined that the patient would typically have already been well-versed in a prescribed and self-administered therapy protocol. The appeal letter dated January 22, 2015 discussed prior treatments and persistent "pain and sensitivity." Therapy including "desensitization" was indicated by the treating provider. It was noted that a prescribed home exercise protocol was provided, that formal supervised therapy was indicated and that additional surgery might be required.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.** : The quantity of prior postoperative therapy visits with outcomes is not documented. It is probable that the patient has been well versed in a prescribed and self-administered protocol. The combination of the subjective and objective findings available does not support other than a prescribed and self-administered therapy protocol. Therefore the request is not medically reasonable and necessary as it is not supported by the ODG clinical guidelines referenced below.

**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)

ODG FOREARM/WRIST/HAND Chapter

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

**Synovitis and tenosynovitis (ICD9 727.0):**

Medical treatment: 9 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