

INDEPENDENT REVIEWERS OF TEXAS, INC.

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[Date notice sent to all parties]:

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Physical Therapy 2 X 8 weeks for left wrist

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

Board Certified PM&R; Board Certified Pain 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female. On XX/XX/XX, the patient was seen regarding a work related injury. She was status post a left deQuervain's release performed on XX/XX/XX. She reported her recovery had been better than it was previously from a right wrist surgery. Pain was rated at 7/10. Her scar was still healing and was scabbed over. She had tenderness to palpation at the proximal and distal to the scar, but just very mild swelling to the hand and finger were noted. She reported mildly severe difficulty with daily task with limited motion at the wrist, grip strength in left hand and wrist with difficulty rising from a seated or lying position. Flexion was 37 degrees with pain and extension was 60 degrees with pain. Radial deviation was 20 degrees with pain and ulnar deviation was 23 degrees with pain. On XX/XX/XX, the patient returned to chiropractic clinic and flexion was rated at 52 degrees, extension 67 degrees, radial deviation 34 degrees, ulnar deviation 39 degrees, supination 90 degrees and pro pronation was 80 degrees. Pain was rated at 5/10 to the right wrist and thumb and 3-4 on left wrist and thumb.

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

On XX/XX/XX, a peer review report was submitted for the requested physical therapy 2 times eight weeks for the left wrist, and Official Disability Guidelines forearm wrist and hand chapter was reviewed. It was noted there were no medical notes from the requesting provider and it was unknown as to if any therapy had been rendered or effects of such therapy. While physical therapy was supported for post-operative care, the patient was approximately five weeks post-surgery and insufficient information was provided to establish the medical necessity of the requested treatment. Therefore the request was non-certified.

On XX/XX/XX, an appeal peer review report for the requested physical therapy two times eight weeks to the left wrist, indicated that there had been 14 visits of physical therapy to date. The patient had been able to be transitioned to a home exercise program, and there was no recent medical records with examinations, deficits or clinical rationale for additional supervised physical therapy from the treating doctor. It was noted the request exceeded guideline based recommendations and the request was not medically necessary.

The guidelines state postop therapy for deQuervain's release is 14 visits over 12 weeks, with fading of treatment frequency to a home program. The records do not document the number of visits previously provided in the form of physical therapy. The efficacy of that treatment has not been documented.

Is the opinion of this reviewer quest for physical therapy two times eight for the left wrist is not medically necessary and prior denials are upheld.

IRO REVIEWER REPORT TEMPLATE -WC

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**
- X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- X 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)**