

# **RYCO MedReview**

**DATE OF REVIEW:** 03/28/07

**IRO CASE #:**

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

Outpatient occupational therapy for the index finger two to three times a week for four weeks

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Hand 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 or not medical necessity exists for each of the health care services in dispute.

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An Employer's First Report of Injury or Illness form dated  
An employee report of injury incident dated  
An immediate supervisor report of employee injury dated  
A workers' compensation incident checklist dated  
An evaluation with, M.D. dated xx/xx/xx  
A TWCC-73 form from Dr. dated 11/29/06

Evaluations with, M.D. dated 01/10/07 and 02/07/07  
X-rays interpreted by Dr. dated 01/10/07  
TWCC-73 forms from Dr. dated 01/10/07, 02/07/07, and 03/07/07  
A physician request from Dr. dated 01/10/07  
An evaluation with an unknown therapist (the signature was illegible) dated 01/11/07  
A request for physical therapy from the unknown therapist dated 01/11/07  
A letter of non-authorization from, R.N.. at IMO dated 01/22/07  
A letter of non-authorization from, L.V.N. at IMO dated 02/13/07  
A reconsideration request from, M.D. dated 03/01/07  
A letter of non-authorization fro, M.D. at IMO dated 03/01/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

On xx/xx/xx, Dr. recommended a digital sleeve and Coban wraps. On 01/10/07 and 02/07/07, Dr. recommended aggressive occupational therapy. An unknown therapist requested therapy two to three times a week for four weeks on 01/11/07. On 01/22/07, Ms. wrote a letter of non-authorization for physical therapy. Ms. also wrote a letter of non-authorization for physical therapy on 02/13/07. On 03/01/07, Dr. wrote a request for reconsideration of physical therapy. On 03/01/07, Dr. wrote a letter of non-authorization for physical therapy.

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

There has not been good documentation provided as to whether the patient is making gains at this time. My main concern is that the original request for the first round of therapy was on 01/10/07. It is now a full two and a half months after and certainly at this point, the patient should be at the point where they received enough therapy to be on a home exercise program. Without further documentation, physical therapy or occupational therapy would go against ODG and ACOEM Guidelines recommendations. There is no thorough explanation of where the patient currently is or what type of therapy this patient would benefit from now that we are two and a half months after the original visit and initial request for therapy that was filled. I am not sure how any kind of therapy to regain range of motion, physical or occupational, would benefit the patient at this time over a home exercise program. Therefore, outpatient occupational therapy for the index finger two to three times a week for four weeks would not be reasonable or necessary.

**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)**