



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 09/13/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twelve sessions of occupational therapy three times a week for four weeks status post repair of a fractured wrist

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.

Twelve sessions of occupational therapy three times a week for four weeks status post repair of a fractured wrist - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X-rays and an MRI of the left knee interpreted by an unknown provider (no name or signature was available) dated 11/05/04

Medical Histories with an unknown provider (no name or signature was available) dated 12/06/04 and 10/16/06

Evaluations with an unknown provider (no name or signature was provided, only initials) dated 12/20/04, 12/23/04, 01/13/05, and 02/07/05

Evaluations with M.D. dated 10/18/06, 11/03/06, 12/08/06, 01/08/07, 02/19/07, 04/27/07, 05/25/07, 07/06/07, and 08/17/07

An operative report from Dr. dated 10/23/06

X-rays of the left wrist interpreted by Dr. dated 11/03/06, 12/08/06, 01/08/07, and 04/27/07

Physical therapy progress summaries from unknown therapists (signatures were illegible) dated 04/11/07, 04/12/07, 05/16/07, 05/18/07, 05/22/07, 05/24/07, 05/28/07, 05/30/07, 06/05/07, 06/07/07, and 06/11/07

A letter of approval from M.D. dated 05/10/07, according to rationale other than Occupational Disability Guidelines (ODG)

Patient Updates from O.T.R. and an unknown therapist (signature was illegible) dated 05/24/07 and 06/05/07

A letter of denial from Dr., according to the ODG, dated 06/14/07

A request note from Dr. dated 06/17/07

A Workers' Compensation Precertification Request from Dr. dated 06/20/07

A letter of denial from M.D. dated 06/28/07, according to the ODG

A fax sheet from Dr. dated 06/28/07

PATIENT CLINICAL HISTORY

X-rays and an MRI of the left knee interpreted by the unknown provider on 11/05/04 revealed chondromalacia in the patellofemoral joint and lateral knee joint compartment, grade II degenerative signal in the lateral meniscus, and a joint effusion. On 12/23/04, an unknown provider recommended a second injection and possible knee surgery. On 01/13/05, the unknown provider prescribed Bextra. On 10/18/06, Dr. recommended knee surgery. Dr. performed a left distal radius ORIF on 10/23/06. On 11/03/06, Dr. placed the patient in a Muenster cast. On 12/08/06, Dr. recommended physical therapy. On 02/19/07, Dr. recommended additional therapy. Physical therapy was performed with unknown therapists from 04/11/07 through 06/11/07 for a total of 11 sessions. On 05/10/07, Dr. wrote a letter of approval for further occupational therapy. On 06/14/07, Dr. wrote a letter of denial for 12 more sessions of physical therapy. On 06/28/07, Dr. wrote a letter of denial for 12 more sessions of physical therapy. On 08/17/07, Dr. recommended vigorous exercise to the wrist.

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

This surgery occurred nearly months ago. The patient has received therapy for this injury already. The requested therapy this far out status post surgery would be outside of what is part of the normal ODG Guidelines for therapy and normal treatment for a distal radius fractures. Based on the medical records, the patient is nearly a year status post surgery and is still experiencing stiffness. Nearly a year out, it is very unlikely that a short course of occupational therapy like this would significantly change her situation. Therefore, the twelve sessions of occupational therapy three times a week for four weeks status post repair of a fractured wrist 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 AND KNOWLEDGE BASE
- 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)**