Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: **DECEMBER 30, 2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational Therapy (3x3) = 9 Visits, to include: 97003, Occupational Therapy Exercises Left Thumb (3xwk x 3wks); 97110, Physical Therapy Exercises Left Thumb (3xwk x 3wks); 97035 Ultrasound, Each 15 minutes Left Thumb (3xwk x 3wks); 97140 Manual Therapy Techniques Left Thumb (3xwk x 3wks); G0283 Electrical Stimulation Left Thumb (3xwk x 3wks).

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management

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.

The reviewer finds that medical necessity does not exist for Occupational Therapy (3x3) = 9 Visits, to include: 97003, Occupational Therapy Exercises Left Thumb (3xwk x 3wks); 97110, Physical Therapy Exercises Left Thumb (3xwk x 3wks); 97035 Ultrasound, Each 15 minutes Left Thumb (3xwk x 3wks); 97140 Manual Therapy Techniques Left Thumb (3xwk x 3wks); G0283 Electrical Stimulation Left Thumb (3xwk x 3wks).

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a xx year old woman who was reportedly injured on xx/xx/xx. She underwent a left thumb trigger finger release on 8/22/08. She had complaints of fullness about the incision. The patient had no further triggering or restricted thumb motion in Dr. ' notes after surgery. He wrote that there was no tingling or paresthesisas. He did not comment of any patient pain. There was the thumb pain in the diagnosis code, but this was related to the original complaint. Dr. wrote in his notes regarding several of this patients' visits that, "The left thumb incision has healed without signs of infection or discharge. She has thickening under the incision. The thumb is ranging well without triggering. The patient's full sensation with brisk capillary refill." His therapy request is for tissue mobilization to improve ADL function and decrease pain. However, there were no comments of pain nor of impaired ADL activities in the records provided for this review.

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

The ODG recognizes the role for occupational therapy after trigger finger release. In fact, it recognizes that 9 visits may be necessary over eight weeks. However, according to the medical records provided for review, this patient has done well and Dr. did not describe any pain or functional loss in repeated notes regarding this patient. Therefore, there is nothing in the medical records which would necessitate the requested therapy. The reviewer finds that medical necessity does not exist for Occupational Therapy (3x3) = 9 Visits, to include: 97003, Occupational Therapy Exercises Left Thumb (3xwk x 3wks); 97110, Physical Therapy Exercises Left Thumb (3xwk x 3wks); 97035 Ultrasound, Each 15 minutes Left Thumb (3xwk x 3wks); 97140 Manual Therapy Techniques Left Thumb (3xwk x 3wks); G0283 Electrical Stimulation Left Thumb (3xwk x 3wks).

Physical/ Occupational therapy Recommended.
Positive (limited evidence)…. 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**….**
Trigger finger (ICD9 727.03):
Post-surgical 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)**