

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 09/10/2008

**IRO CASE #:**

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

This case was reviewed by a Pain Management, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

12 sessions of occupational therapy

### **REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o September 5, 2008 letter
- o June 11, 2008 utilization review report
- o August 5, 2008 utilization review report
- o May 16, 2008 operative report by, M.D.
- o November 9, 2007 operative report by, M.D.
- o January 10, 2008 through June 25, 2008 records from Hand and Upper Rehabilitation
- o November 26, 2007 through April 22, 2008 chart notes by, M.D.
- o November 5, 2007 through June 27, 2008 treatment history created by

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving multiple animal bites of the right thumb and forearm. She subsequently underwent a right thumb extensor tendon laceration tenolysis on November 5, 2007. A request for additional occupational therapy was non-certified on July 11, 2008 in utilization review. The report notes that the patient had 23 approved physical therapy/occupational therapy sessions previous to the request. The reviewing physician stated that the request exceeds the ODG guidelines. Physician generated information had apparently not been supplied.

The case was again reviewed on August 5, 2008 and another non-certification rendered. The report notes that the patient attended approximately 21 sessions of occupational therapy post-operatively with reportedly continued decreased left grip strength. The report states that the patient saw a plastic surgeon on July 15, 2008, noting the left hand scar was soft and range-of-motion was better. The right hand had swelling and a hypertrophic scar. She tried elastic compression and a home spica with dynamic pulley on the proximal interphalangeal joint. The plastic surgeon recommended continuation of exercises, massage, and therapy. The physician reviewer stated that based on the ODG, the patient has received extensive therapy and she should continue on a home exercise program with massage therapy on splinting and compression wraps.

The records include a September 5, 2008 outlining the insurance company's response to the disputed services. The letter states that the patient had the original surgery performed on November 9, 2007. She had additional surgery on May 16, 2008 to remove the scar from the MCP to the IP joints, open capsulectomy of the IP and MCP joints, release and neurolysis of the digital nerve on the ulnar and radial side, and tenolysis of the extensor tendon. Between November 9, 2007 and May 16, 2008, she underwent 30 sessions of occupational and physical therapy. After the May 16, 2008 repair, she had another 23 sessions of occupational and physical therapy with no change in treatment. Review of the physical therapy/occupational therapy notes reflects the clinical plateau in treatment leading the insurance carrier to the conclusion that she has reached maximum medical improvement with respect to occupational/physical therapy. The report states that the ODG does not have a precise model to follow for post-removal of the scar, capsulectomy, neurolysis of the digital nerve, and tenolysis of the extensor tendon. The nearest approximation is post-surgical treatment/ligament repair of the elbow/forearm of 24 sessions over 16 weeks. The letter further states that the guidelines recommend 36 and 48 sessions for post-replantation surgery of the thumb and hand respectively, situations not approximating the surgical procedure of May 16, 2008.

The most recent occupational therapy progress note is dated June 25, 2008. The report states that the patient is independent with self-care using the left hand. Her pain level is zero of 10 at rest and 2-3 of 10 with writing. The goals were to prevent deformity, increase active motion of the right thumb to within normal limits, increase right thumb and left strength, and control scar formation. The most recent physician chart note is dated April 22, 2008 which is prior to her last surgical repair.

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

I agree with the previous opinions that the Official Disability Guidelines do not specifically address this patient's situation. However, the guidelines for ligament repair and post-replantation surgery of the thumb and hand can be used as approximate guides. I agree that the complexity of the patient's last surgery does not approximate post-replantation surgery of the thumb and hand to warrant 36 to 48 sessions of occupational therapy. Based on the patient's most current examination findings, functionality, and estimates derived from the Official Disability Guidelines, the 23 sessions of occupational/physical therapy rendered following the most recent surgery should suffice. Therefore, my recommendation is to uphold the previous determinations to non-certify the request for an additional 12 occupational therapy sessions.

The IRO's decision is consistent with the following guidelines:

**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

Official Disability Guidelines (2008)/Forearm, Wrist, & Hand:

Physical/ Occupational therapy

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ( $p < 0.05$ ). (Rapoliene, 2006)

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.

Fracture of carpal bone (wrist) (ICD9 814):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of metacarpal bone (hand) (ICD9 815):

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

Fracture of radius/ulna (forearm) (ICD9 813):

Post-surgical treatment: 16 visits over 8 weeks

Dislocation of wrist (ICD9 833):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

Dislocation of finger (ICD9 834):

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

Trigger finger (ICD9 727.03):

Post-surgical treatment: 9 visits over 8 weeks

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

Mallet finger (ICD9 736.1)

16 visits over 8 weeks

Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):

Post-surgical treatment: 12 visits over 8 weeks

Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):

Post-surgical treatment: 18 visits over 6 weeks

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Sprains and strains of wrist and hand (ICD9 842):

9 visits over 8 weeks

Sprains and strains of elbow and forearm (ICD9 841):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

Open wound of finger or hand (ICD9 883):

9 visits over 8 weeks. See also Early mobilization (for tendon injuries).

Pain in joint (ICD9 719.4):

9 visits over 8 weeks

Arthropathy, unspecified (ICD9 716.9):

Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

Amputation of thumb; finger (ICD9 885; 886):

Medical treatment: 18 visits over 6 weeks

Post-replantation surgery: 36 visits over 12 weeks

Amputation of hand (ICD9 887):

Post-replantation surgery: 48 visits over 26 weeks

Work conditioning (See also Procedure Summary entry):

12 visits over 8 weeks