



# Lumetra

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 04/27/09

**IRO CASE #:**

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

Continued Occupational Therapy 3 x week x 4 weeks

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

Certified by the American Board of Orthopaedic Surgery

### **REVIEW OUTCOME**

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
12/29/2008	99J0000557284	Prospective	820.13		Upheld

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

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 3/25/09, 2/25/09, and 7 pages of undated physician notes

Occupational Therapy updated plan of care dated 3/16/09

Treatment history

Official Disability Guidelines provided: Forearm, Wrist & Hand (Acute and Chronic)-  
Physical/Occupational therapy

### **PATIENT CLINICAL HISTORY:**

This is claimant fell from a roof and sustained multiple fractures on xx-xx-xx. The claimant underwent surgical intervention for the fractures and has had physical and occupational therapy. Examination of 3/25/09 noted marked loss of wrist range of motion (“profoundly stiff”) with no dorsiflexion or supination beyond neutral, with an associated osteopenia and suggestion of a possible reflex sympathetic dystrophy. Wrist radiographs noted “no change in hardware” and the fracture fragments to be aligned. The wrist fracture involved the distal end of the ulna and radius.

The Reviewer noted that the claimant had already undergone 30 sessions of physical therapy and 24 sessions of occupational therapy. It was also noted that there was no discussion of a home program or an increase in active therapies as opposed to the passive modalities reported.

Per the Reviewer, the occupational therapy (OT) notes presented for review do not report any efficacy or utility with the OT that has been completed.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

As noted in the Division mandated Official Disability Guidelines, there are specific limitations on how much therapy is delivered. The most important factor that is applied in this determination is objectification of the utility and increased functionality. Post-surgical treatment is, at most, 16 visits. The claimant has exceeded this by 50% already and there is no note or objectified improvement in the overall clinical situation.

Thus, while noting that the ODG are simply *guidelines*, there has to be objectified improvement to go outside these parameters. The documents provided for review failed to present any data indicating that continued occupational therapy would serve the best interests of the claimant.

Therefore, in the Reviewer’s opinion, the request for continued occupational therapy is not supported by the submitted clinical information. This is in keeping with the statute and applicable sections of the Division mandated Official Disability 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**