

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/09/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational Therapy for the right wrist, 3x/week x 4 weeks (12 sessions)

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

MD, Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Office notes, Dr. 12/16/08, 02/03/09
Occupational therapy evaluation, 12/29/08
Occupational therapy note, 02/02/09
Prescription for hand therapy, 02/03/09
Occupational therapy re-evaluation, 02/04/09
Request for Occupational therapy, 02/05/09, 02/10/09
Adverse Determination Letters, 2/10/09, 2/11/09

PATIENT CLINICAL HISTORY SUMMARY

This claimant is a male who is status post surgery for a triangular fibrocartilage complex tear completed on xx/xx/xx. Dr. saw the claimant on 12/16/08 at which time it was noted that the claimant was doing well. His pin tracks were clean, the distal radioulnar joint was stable and he had smooth arc of motion to supination and pronation. Wrist sprain/strain was diagnosed. The cast was discontinued and the claimant was put in a brace and advised to start therapy that began on 12/29/08. Dr. re-evaluated the claimant on 02/03/09 and documented that he was making good progress, but was about a month away from full recuperation. There was still a little sensitivity and weakness to grip on examination. He was taking anti-

inflammatories. Joint effusion of the forearm was added to his diagnoses. Mobic, wrist wrap and continuation of therapy for 3-4 more weeks were recommended. A therapy note dated 02/04/09 noted the claimant's reports of right upper extremity weakness. He reported 60 percent improvement of his condition, compliance with a home exercise program, continued improvement with decreasing symptoms. Active wrist motion was: extension 55 degrees, flexion 35 degrees, radial deviation 20 degrees, ulnar deviation 30 degrees, supination 55 degrees, pronation 70 degrees. Right grip strength was 55 compared to 100 on the left. The therapist noted him to be independent with his home exercise program and noted problems of decreased motion and strength and tenderness to palpation. Additional therapy was recommended, but denied on two reviews.

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

The reviewer finds that further physical therapy and occupational therapy is not medically indicated and appropriate. The claimant is noted to have had fibrocartilage complex surgery on 11/14/08, more than three months ago. He has already had at least 12 sessions of occupational therapy to date. There is no physician documentation noting any complications postoperatively. The request exceeds the recommendations in the ODG. Based on the documentation further occupational therapy is not indicated and appropriate. The reviewer finds that medical necessity does not exist for Occupational Therapy for the right wrist, 3x/week x 4 weeks (12 sessions).

ODG – Forearm, Wrist and Hand - Dislocation of wrist

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

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE A DESCRIPTION)