



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 10-26-09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy x 12 to the left wrist 97110(3), 97140

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

American Boards of Physical Medicine and Rehabilitation and 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 9-2-09 MD., office visits on 9-2-09 and 9-22-09.
- 9-10-09 Physical therapy evaluation.
- 9-17-09 MD., Request.
- 9-17-09 DO., performed a Utilization Review.
- 9-25-09 DO., performed a Utilization Review.
- 10-7-09 MD., Rebuttal letter.

PATIENT CLINICAL HISTORY [SUMMARY]:

Medical records reflect the claimant sustained a work related injury on xx/xx/xx. On this date, the claimant reported in an attempt to lift up some material that weighs about 75 pounds and her left hand and wrist bent backwards.

9-2-09 , MD., The claimant presents today for examination of injuries sustained while on the job. She attempted to lift up some material that weighs about 75 pounds and her left hand and wrist bent backwards. She felt immediate pain and cramping. She continued working for about another hour and could not continue due to the pain. Claimant complains of constant achy pain in the left wrist and has increased pain with colder weather. She has palpitations with medication and has trouble sleeping due to the pain. Current medications: Etodolac. MRI of the left wrist 1/16/08 was normal. Left Wrist: Healed vertical scar at distal ulnar side. Moderate tenderness at the ulnar volar side and edema is present. Ulnar deviation is painful. Full DF/VF, Radial/Ulnar deviation. Able to make a fist. Sensation to light touch is intact in median and ulnar distribution. Grip strength 5/5. Diagnosis: Left wrist tenosynovitis. Post surgical, ganglion cyst. Plan: DD 5-9-08 gave her 5% IR and MMI 4-21-08 and RTW with no restriction. Psych evaluation 7/20/09. Therapy completed X 5. Physical therapy evaluation for therapy. Wrist surgery 2/18/08 and has never had post surgical therapy.

Orthopedic referral recommended. EMS, TA, HP given for home use. Follow up in 4 weeks. Discontinue Etodolac. Claimant was prescribed Mobic.

9-10-09 Physical therapy evaluation.

9-17-09 MD., The evaluator noted that he believes that this claimant deserves reconsideration for the adverse determination and that an active physical therapy program is medically necessary.

On 9-17-09 DO., performed a Utilization Review. It was his opinion that specific time limited goals and endpoints of care for the requested therapy sessions are not indicated. Physical therapy note dated 9-10-09 indicates that the patient has had five postoperative physical therapy sessions as of 5-11-09. Submitted physical therapy notes do not provide objective evidence of functional improvement with therapy rendered. There is no indicated goal towards advancement to an independent home exercise program. There is insufficient information regarding the rationale for further therapy from the requesting provider's perspective. With insufficient clinical justification for the proposed therapy, medical necessity of 12 physical therapy visits is not established.

9-22-09 MD., Claimant presents today for a follow up physical performance evaluation to verify subjective findings/complaints and to determine progress and/or the need for further care for her left wrist. She is post surgical for her left wrist and she complains of a constant burning pain in her left wrist and achy pain in her left wrist. She complains of numbness in her left little finger that comes and goes. She complains of pain in her left wrist with extension and radial and ulnar movements. She states that using a wrist brace helps to alleviate the pain/discomfort in her left wrist and she only takes her medications only as needed. She has to use her wrist braces when she does things involving lifting or grasping or carrying things and using her left wrist. She gets relief from her pain/discomfort when she uses the paraffin bath, moist heat and electrical stimulation. She is still having some difficulty with some of her ADL's and notes that her left wrist pain increases with too much use or strenuous activities. She is sleeping a little better at night but still wakes during the night several times due to pain/discomfort in her left wrist. With the range of motion test, she notes a pulling pain and tightness in her left wrist with the movements today. With the manual muscle test, she had mild pain in her left wrist with the test today and was guarding some during the test today. With the grip test, she did not have any pain in her left wrist today with the test; she did say she felt weak. With the lift tests, she notes pain in her left wrist with the arm, leg, torso, floor, high near and high far lifts today. She states that her pain level increased some after completing the test today.

On 9-25-09 DO., performed a Utilization Review. It was his opinion that the appeal letter submitted states that more visits maybe needed when grip strength is a problem. In clinic note dated 9-2-09, the patient's grip strength is noted to be 5/5. Additionally, clinic note 5-9-08 states that the patient has reached maximum medical improvement and her clinical condition is not likely to improve with further active medical treatment.

This appeal failed to specify the precise duration and frequency of therapy visits, which were noted to be lacking by the previous adverse determination. The specific therapy goals were not provided to determine the medical necessity of the requested service; therapy goals should not merely focus on achieving objective improvements but should seek to establish functional correlations with the therapeutic gains. There is no documented home exercise program in place at the START of the treatment regimen. Additional information is needed to substantiate the medical necessity of this request.

10-7-09 MD., The evaluator noted that he believes that this claimant deserves reconsideration for the adverse determination and that an active physical therapy program is medically necessary. The evaluator reported 1) The grip strength of 5/5 on clinic note of 9/2/09 refers to neurological testing to assess injury at the nerve root level(s) specifically C8 (finger flexors) and should not be confused with actual muscle testing (for strength) using a digital dynamometer performed during a PPE (Physical Performance Evaluation) which is attached to document grip weakness. Again, the specific time limited goals and end points of care for the requested therapy sessions are indicated on the 2nd page of the therapy note of 9/10/09. The PT evaluation plan of care recommended post-op PT to the left wrist 3x4 with goals of treatment to include decrease pain, increase ROM, and increase strength. Frequency of 3x4 means "3 visits per week for 4 weeks"; we cannot clarify this any further. Even though the patient has full ROM this does not indicate that the ROM is pain free and there is documented weakness as noted on the PPE of 9/22/09 and full ROM with pain on ulnar deviation as indicated on the PT evaluation of 9/10/09. Clearly, there is room for functional improvements; furthermore, the patient cannot be expected to be at MMI when physical therapy has not been exhausted. The patient only completed 5 supervised post-op physical therapy visits and ODG guidelines recommend 18 post- surgical PT visits (Referenced: ODG, Online Edition; Chapter: Forearm, Wrist, & Hand); as such, this request is consistent with ODG and evidence based guidelines and medical necessity has been established. Furthermore, more visits may be necessary when grip strength is a problem, even if ROM is improved (Referenced; ODG, Online Edition; Chapter: Forearm, Wrist, & Hand). After the conclusion of the 18 post-surgical recommended sessions, the patient will progress to an independent HEP (home exercise program).

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

MEDICAL RECORDS REFLECT A CLAIMANT WHO UNDERWENT SURGICAL INTERVENTION IN 2008 AND HAD 5 POST-OP PHYSICAL THERAPY VISITS. THE CLAIMANT CONTINUES WITH WEAKNESS, STIFFNESS AND PAIN. THERE IS NO MENTIONING OF A HOME EXERCISE PROGRAM THAT IS BEING PERFORMED TO INCREASE HER STRENGTH. BASED ON DOCUMENTATION PRESENTED, PARTIAL-CERTIFICATION IS PROVIDED FOR THREE VISITS IN ORDER TO TEACH THE CLAIMANT A HOME EXERCISE PROGRAM.

ODG-TWC, last update 9-23-09 Occupational Disorders of the Forearm, wrist and hand – physical 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):

Medical treatment: 16 visits over 8 weeks

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

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 KNOWLEDGBASE
- 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)**