P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 02/26/2010

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 (Board Certified), 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 Occupational Therapy visits between 1/20/2010 and 3/21/2010

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

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 12-01-09 UR Determination letter - 12 sessions of PT non-certified, from Dr.
- 12-10-09 Occupational therapy progress note from OTR
- 12-16-09 PT Treatment Encounter Notes covering dates 12-16-09 - 12-23-09- visits 5-8/12.
- 12-23-09 Invoice for PT from Dr. Newton
- 01-04-10 PT order for PT 12 for laceration extensor tendon right index finger from Dr.
- 01-13-10 Occupational Therapy Progress Note from OTR
- 01-14-10 Fax Preauthorization request for therapy from Dr.
- 01-19-10 Adverse Determination Letter
- 01-25-10 Review for 12 sessions of occupational therapy
- 01-25-10 Adverse Determination Letter for Reconsideration Occupational Therapy
- 02-05-10 Request for IRO from the Claimant
- 02-08-10 Confirmation of Receipt of IRO from TDI
- 02-09-10 Notice Of Case Assignment, IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female f who sustained an industrial injury to the wrist and hand on xx/xx/xx when she was knocked down. She is status post attempted closed reduction resulting in ORIF with hand innovation distal radius plating system. She also underwent exploration of the right index finger extensor digitorum communis tendon at the metacarpophalangeal joint and at the wrist with reconstruction using extensor digitorum radialis graft on October 21, 2009. The patient initiated occupational therapy on November 2, 2009. She has attended 24 sessions of occupational therapy for a diagnosis of closed fracture of carpal bone,

nontraumatic rupture of extensor and acquired deformity of a limb.

Request for 12 additional sessions of occupational therapy (11/25/09 through 01/24/10) was considered in review on December 1, 2009 with recommendation for certification. The reviewer noted that patient had undergone multiple, extensive surgical procedures to repair multiple structures in her dominant hand/upper extremity with the most recent procedure performed only 7 weeks prior. The records noted she had attended 8 of 9 OT sessions as of 11/24/09 and that she has progressed with treatment. Additional sessions for the right hand and wrist were deemed reasonable.

The patient was reassessed in PT on December 10, 2009. The diagnosis is rupture of the EDC of the index finger, status post repair of the EPL tendon and volar wrist fracture. Since initiating PT on November 12, 2009 the patient has completed 12 sessions. She continues to be provided paraffin, ultrasound, soft tissue release techniques for scar tissue, stretching and gentle wrist stretches and neuromuscular electrical stimulation to encourage extension of the index finger. She currently has a 20-degree lag at the MCP joint and is hoping to decrease this with muscle strengthening using neuromuscular stimulation muscle. She is still wearing the dynamic extensor tendon extension splint. We recommend active therapy with strengthening when the splint is removed. Handwritten notes indicate left grip strength is 40 pounds versus 20 pounds right grip.

PT treatment notes covering visits 5-8/12 have been submitted. Treatment content is both active and passive. On 12/16/09 the patient has removed the splint. The neurostimulation is really helping with active extension (12-17-09). She is tolerating the treatment very well (12-23-09). Active therapy notes continue through 12/28/09.

Occupation therapy progress notes of January 13, 2010 indicate the patient has completed 24 visits since November 2, 2009. She is making very good progress in gaining strength and range of motion in her left hand. Grip strength is 15, 20, 20 pounds on the right. Lateral pinch is 8,9,8 pounds and tripod pinch is 3,4,3 pounds. Left grip strength is 40 pounds. W rist flexion is 55 degrees (normal = 90) and extension 45 degrees (normal = 70). Supination and pronation are both 70 degrees. Range of motion of the digits is as follows: Index finger: MCP 20-60 degrees (normal = 90), PIP 0-80 degrees (normal = 80) and DIP 0-55 degrees (normal =80). Middle finger: MCP 0-60 degrees, PIP 0-90 degrees and DIP 0-55 degrees. She continues to have problems with extensor tendon lag on the index finger of about 20 degrees and she is still lacking adequate PIP flexion in both the index and long fingers, and is lacking several degrees of about 10-20 degrees of MCP flexion in each of those digits. She is right hand dominant and grip strength is lacking of about 20 pounds. Her pinch strengths are about 3-4 pounds difference. She is recommended to continue therapy to work on grip strengthening. With NMES she has gained active MCP extension of the index finger.

Request for 12 sessions of occupational therapy was considered in review on January 19, 2010 with recommendation for non-certification. Per the reviewer, as of December 10, 2009 the patient had completed 12 sessions of PT. There was no thorough evaluation by the providing physician to establish the current functional status of the right hand. There were no exceptional factors noted to warrant further supervised PT beyond the recommended duration by the cited guidelines. The specific treatment goals to define the endpoint of care were not stated. A peer discussion was attempted but not realized.

Request for reconsideration 12 sessions of occupational therapy was considered in review on January 25, 2010 with recommendation for non-certification with rationale that the amount of therapy exceeds ODG recommendations for the patient's diagnosis and the provider has not documented a rationale for ongoing formal therapy versus an aggressive home exercise program. The patient has completed 24 sessions of occupational therapy. Index ROM was noted as follows: 20-60 degrees for the metacarpophalangeal joint, 0-80 degrees proximal interphalangeal, 0-55 degrees distal interphalangeal. Middle finger ROM was noted as 0-60 degrees metacarpophalangeal, 0-90 degrees proximal interphalangeal, 0-55 degrees, distal interphalangeal. The patient reportedly has persisting problems with extensor tendon lag on the index finger of about 20 degrees, and is still lacking adequate proximal interphalangeal flexion in both the index and long fingers. There is a 20-pound difference in left and right grip strength. A peer discussion was attempted but not realized. ODG recommends 16 post-op visits for the patient's fracture repair and 9 visits for the laceration.

Request was made for an IRO.

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

ODG supports 16 visits of PT over 8 weeks following surgical repair of radial and/or ulnar fractures and 9 visits of PT over 8 weeks for open wounds of the finger or hand.

The patient was knocked down by a forklift and sustained a laceration to the right hand and radial fracture. She underwent ORIF with hand innovation distal radius plating system on June 30, 2009, exploration of right index finger extensor digitorum communis tendon at the MCP joint and at the wrist with reconstruction using extensor digitorum radialis graft on October 21, 2009 and has attended 24 sessions of post-operative occupational therapy with concurrent use of a splint. The splint is now removed. PT assessment notes the patient continues to have problems with extensor tendon lag on the index finger of about 20 degrees and she is still lacking adequate PIP flexion in both the index and long fingers, and is lacking several degrees, about 10-20 degrees, of MCP flexion in each of those digits. She is right hand dominant and grip strength is lacking of about 20 pounds.

Per the first-line reviewer, there was no thorough evaluation by the providing physician to establish the current functional status of the right hand. There were no exceptional factors noted to warrant further supervised PT beyond the recommended duration by the cited guidelines. The specific treatment goals to define the endpoint of care were not stated. Per the second-line reviewer, the amount of therapy exceeds ODG recommendations for the patient's diagnosis and the provider has not documented a rationale for ongoing formal therapy versus an aggressive home exercise program. A peer discussion was not successful to obtain additional rationale from the provider.

There is no mention in the PT notes or reassessment that the patient has been instructed in HEP which is a standard of PT care. The patient has been performing ball stretches, wax squeeze, pinch pins, grip, Theraband exercises and finger rolls in supervised PT which she could be also performing in an independent exercise program with a few off-the-shelf exercise DME items. At this time an extended period of supervised PT would not be supported per ODG guidelines.

Therefore, my recommendation is to agree with the previous non-certification of the request for 12 Occupational Therapy visits between 1/20/2010 and 3/21/2010.

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

__X___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

The Official Disability Guidelines (01-12-2010) 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. 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.

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.

Fracture of radius/ulna (forearm) (ICD9 813): Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 16 visits over 8 weeks

Open wound of finger or hand (ICD9 883): 9 visits over 8 weeks.