

Clear Resolutions Inc.

An Independent Review Organization
7301 RANCH RD 620 N, STE 155-199A
Austin, TX 78726
Phone: (512) 772-4390
Fax: (512) 519-7316
Email: resolutions.manager@cri-iro.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Occupational Therapy 3xWk x 4Wks Left wrist and left hand

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Doctor of Medicine (M.D.), Board Certified in Orthopaedic Surgery
Fellowship Trained in Hand Surgery

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

OD Guidelines
Denials, 8/18/10, 7/23/10
MD, Clinic Notes from 7/21/09 to 8/23/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is five months status post multiple tendon reconstructions median nerve repair and opponensplasty of soft tissue injuries associated with an open radial and ulnar shaft fracture. The patient has participated in twenty-three postoperative hand therapy visits. The patient continues to have limited active range of motion with good passive range of motion. The hand surgeon has requested more therapy for this patient to include Occupational Therapy 3xWk x 4Wks Left wrist and left hand.

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

This complex case does not adequately conform to the ODG guidelines. The patient has had multiple and extensive soft tissue reconstruction of the upper extremity. The patient is five months status post multiple tendon reconstructions median nerve repair and opponensplasty of soft tissue injuries associated with an open radial and ulnar shaft fracture. The patient has not adequately regained full functional range of motion, however progress is being made according to the provider's notes. Based on the records reviewed, this reviewer agrees with the patient's provider that a home exercise program only would be inadequate for this patient and that the requested occupational therapy is medically necessary for this patient. Upon

independent review, the reviewer finds that the previous adverse determination/adverse determinations should be overturned. The reviewer finds that medical necessity exists for Occupational Therapy 3xWk x 4Wks Left wrist and left hand.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION – Green’s Operative Hand Surgery

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