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Notice of Independent Review Decision

**DATE OF REVIEW:** MARCH 28, 2011

**IRO CASE #:**

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

Physical Therapy 3xWk x 4Weeks-97410x2, 97112x1, 97018x1-left wrist

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

This physician is a Board Certified Physical Medicine & Rehabilitation Physician with 14 years of experience.

**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**

On XX/XX/XXXX, the claimant presented to the emergency department with complaints of a slip and fall injury to her left wrist with swelling and pain. She denies numbness and tingling. Impression: Distal radius and ulnar fracture of the wrist.

On XX/XX/XXXX, x-rays of the left wrist/forearm were performed. Impression: Colles-type fracture at the wrist with impaction and angulation as interpreted by M.D.

On XX/XX/XXXX, the claimant was evaluated by M.D. Associated symptoms bony deformity, decreased range of motion, joint swelling. She was referred to an orthopedic surgeon.

On XX/XX/XXXX, the claimant was evaluated by M.D., an orthopedic surgeon. Surgical intervention was recommended.

On XX/XX/XXXX, the claimant underwent surgical intervention of the left wrist as performed by M.D. Procedure: Open reduction internal fixation of the left distal radius intraarticular fracture greater than three parts.

On XX/XX/XXXX, the claimant was referred to clinic for postoperative physical therapy. Physical therapy 2-3 times per week for 6 weeks was recommended.

On XX/XX/XXXX, the claimant was seen at clinic for a occupational therapy evaluation. She is to be seen 2 times a week for 4 weeks.

On XX/XX/XXXX, the claimant was seen at clinic for a physical therapy evaluation. She is to be seen 3 times per week for 4 weeks.

On XX/XX/XXXX, the claimant was re-evaluated at clinic. She has participated in 6 physical therapy sessions. The reports continued left wrist pain. Left wrist flexion was 35 degrees, extension 30 degrees, radial deviation 5 degrees and ulnar deviation 15 degrees. Her left grip strength is 10 pounds.

On XX/XX/XXXX, the claimant was re-evaluated by M.D. She is doing as expected and has been attending physical therapy. X-rays showed good reduction of the distal radius fracture with the plate and hardware in place. She should no longer use the removable brace.

On XX/XX/XXXX, the claimant attended her 10<sup>th</sup> visit at clinic. She is still lacking wrist flexion.

On XX/XX/XXXX, D.O., a physical medicine and rehabilitation physician, performed a utilization review on the claimant. Rationale for Denial: Documentation indicates that the patient underwent ORIF of the left distal radius on XX/XX/XXXX. ODG's suggest up to 16 sessions of physical therapy for the patient's diagnosis. Nurse case manager notes indicate the patient has completed 16 sessions of treatment to date. The request for 12 additional sessions, combined with prior treatment would exceed evidence based guidelines for total duration of care. Therefore, it is not certified.

There is a note dated XX/XX/XXXX from Dr. She has completed 6 therapy visits at clinic. She has one visit at clinic but decided she wanted to have her treatment at a different clinic.

On March 4, 2011, M.D. an orthopedic surgeon performed a utilization review on the claimant Rational for Denial: Guidelines suggest maximum of 16 sessions over 8 weeks post-op. The patient has passed that time frame and is now XX weeks post-op. Therefore, it is not certified.

#### **PATIENT CLINICAL HISTORY:**

On XX/XX/XXXX, the claimant sustained an injury to the left wrist when she slipped and fell over a cord.

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

Denial of additional 12 PT visits for the left wrist is upheld/agreed upon. Submitted therapy documentation indicates 2 therapy evaluations on 1/4/11 and 1/10/11 and completion of only 10 post op PT treatment visits. Since ODG Wrist Chapter recommends 16 post op treatment visits for a distal radius fracture, request for additional 12 PT post op visits (for a total of 22 visits) exceeds ODG recommendations.

## **ODG Physical Therapy Guidelines –**

General: Up to 3 visits contingent on objective improvement documented (ie. VAS improvement of greater than 4). Further trial visits with fading frequency up to 6 contingent on further objectification of longterm resolution of symptoms, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

### **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

### **Lateral epicondylitis/Tennis elbow (ICD9 726.32):**

Medical treatment: 8 visits over 5 weeks

Post-surgical treatment: 12 visits over 12 weeks

### **Medial epicondylitis/Golfers' elbow (ICD9 726.31):**

Medical treatment: 8 visits over 5 weeks

Post-surgical treatment: 12 visits over 12 weeks

### **Enthesopathy of elbow region (ICD9 726.3):**

Medical treatment: 8 visits over 5 weeks

Post-surgical treatment: 12 visits over 12 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

### **Olecranon bursitis (ICD9 726.33):**

Medical treatment: 8 visits over 4 weeks

### **Dislocation of elbow (ICD9 832):**

Stable dislocation: 6 visits over 2 weeks

Unstable dislocation, post-surgical treatment: 10 visits over 9 weeks

### **Fracture of radius/ulna (ICD9 813):**

Post-surgical treatment: 16 visits over 8 weeks

### **Fracture of humerus (ICD9 812):**

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

### **Ill-defined fractures of upper limb (ICD9 818):**

8 visits over 10 weeks

### **Arthropathy, unspecified (ICD9 716.9):**

Post-surgical treatment, arthroplasty, elbow: 24 visits over 8 weeks

### **Rupture of biceps tendon (ICD9 727.62):**

Post-surgical treatment: 24 visits over 16 weeks

### **Traumatic amputation of arm (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 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)