

# Clear Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Aug/26/2011

**IRO CASE #:**

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

Occupational Therapy three times a week for four weeks on the Left Hand

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

M.D., 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**

Official Disability Guidelines-Treatment for Workers' Compensation, Chapter: Forearm, Wrist and Hand

Operative Report: 01/04/11

Dr. OV: 01/21/11, 02/23/11, 03/28/11, 04/25/11

Dr. Request for PT: 02/23/11 03/02/11, 04/04/11, 07/06/11, 07/13/11, 07/20/11

Physical Therapy Evaluation: 02/28/11

Physical Therapy Progress Note: 04/01/11

**PATIENT CLINICAL HISTORY SUMMARY**

This is a male who sustained a work related comminuted intraarticular fracture of the distal radius with scaphoid lunate ligament tear when he fell on xx/xx/xx. He underwent an open reduction and internal fixation of his left distal radius and an open repair of the scapholunate ligament on 01/04/11 and underwent hardware removal on 02/15/11. Postoperatively he had 17 sessions of therapy. When the claimant saw Dr. on 07/13/11, he had returned to full duty. He complained of pain in his wrist after working. On examination he had decreased range of motion of his left wrist. He had tenderness over the radioscaphoid articulation as well as scapholunate ligament. Dr. diagnosed him with a wrist sprain and recommended anti-inflammatories, pain medication and 12 sessions of occupational therapy.

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

For post surgical treatment, fracture of radius ulna or dislocation of the wrist post surgical treatment, up to sixteen visits over eight to ten weeks is considered appropriate according to ODG. This patient has had seventeen sessions of therapy. Therefore, Occupational therapy three times a week for four weeks on the left hand would not be considered medically necessary based on the records provided in this case.

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 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

**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)

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