

I-Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy/occupational therapy three times a week for four weeks to the left hand

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

M.D., Board Certified Orthopedic 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

ODG Physical/Occupational Therapy Guidelines

Notification of reconsideration determination 10/21/11

Notification of adverse determination 09/16/11

Therapy prescription and request forms

Office visit notes 06/07/11-10/11/11

Physical therapy treatment notes and evaluations 06/08/11-09/19/11

Operative report 05/31/11

Precertification request 09/13/11, 09/28/11, 08/16/11

Designated doctor evaluation 10/20/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a crush injury to the left hand on xx/xx/xx. She underwent surgical intervention on that date with left hand debridement down to the bone, left hand soft tissue rearrangement, left ring finger proximal phalanx open treatment, left 5th metacarpal closed reduction and percutaneous pinning, left hand complex wound repair more than 2.6 cm, extensor tendon repair ring finger zone 4. The claimant participated in postoperative physical therapy beginning 06/08/11 through 09/19/11. On 9/13/11 notes say she is attending formal therapy with improvement in range of motion but still has pain. She is using CPM 3 times a day for 2 hours. She complains of left hand pain 6/10. It occurs with activity predominantly during the daytime. She is currently off work. External immobilization helps symptoms, oral medications help symptoms, therapy helps symptoms, and surgery helps symptoms. Examination of the hand revealed global motion reduced to 50% of normal on the left side. There was first web contracture on the left, mild. The left hand wound is healed with skin with poor quality; there is severe tenderness and hypersensitivity in the area that is variable. She seems to be slowly improving as compared to previous visit. All fingers with generalized stiffness. Two-point discrimination test was reported as 6 mm throughout.

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

This patient sustained significant crush injury to left hand on xx/xx/xx and underwent extensive surgical intervention on that date. She has completed approximately 44 sessions of therapy to date. Most recent office note dated 10/11/11 indicates that she has not been attending formal therapy for approximately 3 weeks following non-authorization of additional therapy. She has been performing home exercise program and notes no significant improvement with range of motion.

It is noted the claimant complains of severe left shoulder mechanical pain and decreased range of motion. On examination of the left hand, global motion was reduced to 50% of normal, with mild first web contracture on left. Noting the extensive treatment to date, with limited improvement, the reviewer finds that Physical therapy/occupational therapy three times a week for four weeks to the left hand is not medically necessary.

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)