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Notice of Independent Review Decision

DATE OF REVIEW: 12/30/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Appeal Occupational Therapy 3xWk x 4Wks 97110 97140
Right Wrist

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

Texas Board Certified Orthopedic Spine Surgeon

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. ODG - Forearm, Wrist, and Hand
2. 07/07/10 - Clinical Note - MD
3. 07/12/10 - Physician Orders
4. 07/12/10 - History and Physical
5. 07/12/10 - Operative Report
6. 08/11/10 - Occupational Therapy Outpatient Evaluation
7. 08/12/10 - Occupational Therapy Treatment Note
8. 08/16/10 - Occupational Therapy Treatment Note
9. 08/18/10 - Occupational Therapy Treatment Note
10. 08/19/10 - Occupational Therapy Treatment Note
11. 08/23/10 - Occupational Therapy Treatment Note
12. 08/25/10 - Occupational Therapy Treatment Note
13. 08/26/10 - Occupational Therapy Treatment Note
14. 08/31/10 - Occupational Therapy Treatment Note

- 15.09/01/10 - Occupational Therapy Treatment Note
- 16.09/02/10 - Occupational Therapy Treatment Note
- 17.09/07/10 - Occupational Therapy Treatment Note
- 18.09/08/10 - Occupational Therapy Treatment Note
- 19.09/09/10 - Occupational Therapy Treatment Note
- 20.09/14/10 - Occupational Therapy Treatment Note
- 21.09/15/10 - Occupational Therapy Treatment Note
- 22.09/16/10 - Occupational Therapy Treatment Note
- 23.09/20/10 - Occupational Therapy Treatment Note
- 24.09/21/10 - Occupational Therapy Treatment Note
- 25.09/23/10 - Occupational Therapy Treatment Note
- 26.09/27/10 - Occupational Therapy Treatment Note
- 27.09/29/10 - Occupational Therapy Treatment Note
- 28.09/30/10 - Occupational Therapy Treatment Note
- 29.10/04/10 - Occupational Therapy Treatment Note
- 30.10/05/10 - Occupational Therapy Treatment Note
- 31.10/07/10 - Occupational Therapy Treatment Note
- 32.10/11/10 - Occupational Therapy Treatment Note
- 33.10/12/10 - Occupational Therapy Treatment Note
- 34.10/12/10 - Utilization Review
- 35.10/14/10 - Occupational Therapy Treatment Note
- 36.10/27/10 - Occupational Therapy Treatment Note
- 37.10/28/10 - Occupational Therapy Treatment Note
- 38.10/28/10 - Utilization Review
- 39.11/01/10 - Occupational Therapy Treatment Note
- 40.11/03/10 - Occupational Therapy Treatment Note
- 41.11/04/10 - Occupational Therapy Treatment Note
- 42.11/04/10 - Designated Doctor Evaluation
- 43.11/04/10 - Report of Medical Evaluation
- 44.11/08/10 - Occupational Therapy Treatment Note
- 45.11/10/10 - Occupational Therapy Treatment Note
- 46.11/11/10 - Occupational Therapy Treatment Note
- 47.11/15/10 - Occupational Therapy Treatment Note
- 48.11/17/10 - Occupational Therapy Treatment Note
- 49.11/18/10 - Occupational Therapy Treatment Note
- 50.11/22/10 - Occupational Therapy Treatment Note
- 51.11/23/10 - Occupational Therapy Treatment Note
- 52.11/29/10 - Occupational Therapy Treatment Note
- 53.12/01/10 - Occupational Therapy Treatment Note
- 54.12/01/10 - Clinical Note - Thomas Reid, MD
- 55.12/02/10 - Occupational Therapy Treatment Note
56. ***Official Disability Guidelines***

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury on xx/xx/xx when he fell backward from a loft that was four feet high and tried to catch himself with the right arm.

The employee saw Dr. Physical examination revealed a displaced angulated and severely shortened fracture of the radius. There was no numbness in the hands. There was pain in the thumb area. Capillary refill was normal. The employee was recommended for open reduction and internal fixation of the radius.

The employee underwent open reduction and internal fixation of the fracture on 07/12/10.

The employee was seen for occupational therapy evaluation on 08/11/10. The employee reported prior injuries due to riding in rodeos. The employee rated his current pain at 8 out of 10 on the visual analog scale. Physical examination revealed decreased range of motion. The note stated the employee tolerated the sessions well. The employee's problem list included decreased range of motion, edema, pain, decreased fine motor coordination, difficulty completing tasks, and impaired functional use of the right upper extremity. The employee was recommended for twelve sessions of occupational therapy.

The employee completed twelve occupational therapy sessions on 09/07/10. The employee continued to have pain and decreased range of motion. The employee was recommended for continued occupational therapy.

The request for Occupational Therapy 3 x wk x 4 wks was denied by utilization review on 10/12/10. If the employee was not yet fully improved, factors of prolonged or delayed recovery should be identified and addressed rather than pursuing a continued therapy that provides no complete benefit. An independent home-based exercise program may be indicated at that time.

The request for Occupational Therapy 3 x wk x 4 wks was denied by utilization review on 10/28/10. With more than substantial number of therapy visits provided, the employee should have been fully progressed into an independent exercise program at this time. In addition, the documentation of response to other conservative measures such as oral pharmacotherapy, in conjunction with rehabilitation efforts, was not provided in the medical records submitted.

The employee was seen for Designated Doctor Evaluation on 11/04/10. The employee complained of pain in the right upper arm, right forearm, and wrist. Current medications included Hydrocodone. Physical examination revealed atrophy of the right upper extremity. There was marked weakness of the right upper extremity. Examination of the right wrist revealed a well-healed surgical scar with no evidence of infection or inflammation. There was marked tenderness over the volar and dorsal aspect of the right wrist. Tinel's was positive on the right side. Phalen's was negative. Examination of the right upper arm revealed marked tenderness over the distal deltoid and biceps. Examination of the right shoulder revealed some drooping of the belly of

the long head of the biceps. There was no sensory deficit noted in either upper extremity. The employee was not placed at Maximum Medical Improvement (MMI) at that time. The employee was recommended for radiographs and MRI of the right upper arm. The employee was also recommended to continue occupational therapy.

The employee saw Dr. on 12/01/10. The employee was doing well with occupational therapy. Physical examination revealed pain in the right shoulder with some swelling of part of the deltoid muscle in a palpable swollen area. The employee was recommended for MRI of the shoulder.

The employee completed forty-two sessions of occupational therapy on 12/02/10. The employee continued to have pain in the upper arm and shoulder. The employee demonstrated increased range of motion. The note stated the employee tolerated the sessions without difficulty. The employee was recommended to continue with occupational therapy.

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

The requested twelve sessions of additional occupational therapy are not recommended as medically necessary for this employee. Per the clinical records, the employee has undergone forty-two sessions of occupational therapy to date. The employee has continued tenderness over the volar and dorsal aspect of the right wrist. There was a positive Tinel's sign. Given these mild functional limitations, continued occupational therapy would not be indicated. The employee has had extensive occupational therapy to date, and the employee should be well-educated in a home exercise program that would reasonably address the employee's remaining deficits. An additional twelve sessions of occupational therapy would not reasonably further improve the employee's current deficits.

As such, medical necessity for the request is not supported.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

Official Disability Guidelines, Online Version, Forearm, Wrist, & Hand Chapter.