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Notice of Independent Review Decision

DATE OF REVIEW: March 4, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

OT 3 x 6 left upper extremity – 97010, 97014, 97018, 97026, 97035, 97022, 97110, 97140, 97530, 97535.

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

Certified, American Board of Orthopaedic Surgery

REVIEW OUTCOME

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

X Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Dr.

- Office notes (08/02/10 – 02/14/11)

Health Care

- Rehab Assessment Notes (10/15/10 – 12/13/10)
- Facsimile (10/27/10 – 01/31/11)
- Utilization Reviews (12/28/10, 01/24/11)
- IRO Request

- Radiodiagnostics (08/02/10 – 11/24/10)
- Office Notes (08/02/10 – 02/14/11)
- Operative Note (08/02/10)
- Rehab Notes (09/28/10 – 01/31/11)
- Electrodiagnostics (12/09/10)
- Utilization reviews (12/28/10, 01/24/11)

TDI

- Utilization Reviews (01/24/11, 02/07/11)

- IRO Request

[ODG has been utilized for the denials.](#)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury on xx/xx/xx, when he was coming down scaffolding with a skill saw in his hand. He fell and the skill saw struck him on his left forearm, creating a large laceration to the left forearm.

Following the injury, the patient was evaluated at Hospital where x-rays were obtained and he was then transferred to Medical Center ER. X-rays of the left forearm showed a comminuted minimally displaced fracture of the proximal shaft of the ulna, small bony fragments in the surrounding soft tissues and associated soft tissue laceration. M.D., noted left arm open wound and left hand ulnar nerve loss of function. There was 6.5-7 cm laceration to the left arm on the ulnar surface and proximal one-third of the volar forearm. He had a jagged laceration through the muscle bellies and down to include open fracture of the ulna. He had loss of sensation over the ulnar one-half of his fourth and fifth finger. Dr. assessed open fracture of ulna, open wound of left forearm, ulnar nerve laceration and laceration of multiple bellies. He performed irrigation and debridement, exploration of left arm wound and repair of multiple extensor and flexor tendon, muscle bellies and repair of ulnar artery and nerve of the left arm and application of splint.

D.O., an orthopedic surgeon, was consulted for management of the left ulnar fracture. He immobilized the arm with application of splint to heal the fracture in a closed fashion and started the patient on antibiotics and Norco for pain. The patient continued to have no sensation or motor function in his ulnar nerve distribution. X-rays of the left arm showed the ulnar fracture to be in anatomic position but a missing small sliver of bone where the saw went through. Dr. applied the Munster type cast for four weeks followed by a short-arm cast. Subsequent x-rays showed persistent fracture gap with some minor fluffiness in that area without formation of fracture callus. Dr. placed an Exogen bone growth stimulator and placed the arm in an ulnar fracture brace to continue the immobilization as fracture had not healed.

From October 5, 2010, through January 20, 2011, the patient attended 42 sessions of occupational therapy (OT) at Medical Center with the modalities consisting of paraffin bath, manual therapy and therapeutic procedures.

With the use of bone stimulator, the patient felt better, but in October, he complained of stiffness and pain in his left shoulder. X-rays of the forearm showed some bridging callus while x-rays of the left shoulder showed osteopenia of the proximal humerus and mild lateral downsloping of acromion. Examination of the shoulder showed restricted ROM. Dr. assessed adhesive capsulitis of the left shoulder secondary to immobilization and initiated therapy for the shoulder as well. PT did not help as regards to the shoulder symptoms. Dr. noted tenderness over the lateral aspect of the acromion and mildly positive Jobe and O'Brien signs.

Magnetic resonance imaging (MRI) of the left shoulder revealed early arthritic changes including minimal inferior marginal osteophyte formation at the

acromioclavicular (AC) joint and type I acromion process with mild anterior and lateral downsloping.

Dr. injected the left subacromial space with dexamethasone and lidocaine and continued aggressive PT for the shoulder.

For residual ulnar nerve issues, M.D., a neurologist, obtained electromyography/nerve conduction velocity (EMG/NCV) study of the bilateral upper extremities that showed severe left ulnar neuropathy at the site of laceration. Of note, there was some minor axonal contiguity.

In December 2010, PT for 12 sessions was denied through preauthorization process. In an appeal letter , OTR, reported the following: The patient was seen for 36 OT visits. His problems included significantly decreased strength and ROM, increased scar tissue, decreased ADL, home management performance and decreased ability to perform work activities. The areas with limited strength and ROM were shoulder, elbow, forearm, wrist and hand. Extended treatment sessions were necessary for the patient as there were several deficits in his left upper extremity. Because of the severity of his injury, he was not referred to therapy until eight weeks postoperatively and was immobilized for eight weeks. This delay in motion had resulted in severe joint contracture in the shoulder and hand. Therefore, additional sessions were imperative.

In January 2011, Dr. noted the patient had made excellent progress in PT with improvement in ROM and strength. He recommended continuing PT to further improve forward flexion, abduction and internal rotation of the shoulder. With regards to ulna, he obtained x-rays of left forearm and noted some hypertrophic callus volarly which appeared to be uniting. Though there was still a radiolucent line in the shaft consistent with delayed union. Dr. continued the bone stimulator for another six weeks and recommended conservative treatment. He stated if the further therapy was not approved for the shoulder, the patient might require operative intervention including possible manipulation under anesthesia with possible arthroscopic capsular release.

On January 24, 2011, per utilization review, request for additional OT 3 x 6 to LUE including 97010, 97014, 97018, 97026, 97035, 97022, 97110, 97140, 97530, 97535 was denied with the following rationale: *"This is a request for additional occupational therapy three times a week for six weeks for the left wrist, hand and shoulder. It is noted that the patient has attended 37 occupational therapy sessions to date. The number of OT sessions requested on top of the previously rendered OT sessions exceeds the guideline recommendations. Furthermore, an updated physical assessment from the primary treating physician was not included in the medical attachments. It is noted that the patient has good performance of home exercise program. There is no evidence that the remaining deficits cannot be addressed by a prescribed and self-administered home exercise program. The medical necessity of this request cannot be established at this point. It does not appear that this patient is making significant amount of progress over the recent month in physical therapy and appears to have plateaued. Based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines, this request for*

OT three times a week for six weeks for the left wrist, hand, and shoulder is non-certified."

On January 25, 2011, Ms. wrote an appeal letter indicating: The patient was recently approved six more visits bringing the total of 42 visits. Because of the delay in therapy services due to a denial in services, the patient experienced a loss in ROM in the fingers. This patient did not have functional use of the LUE. He was not able to use the arm for any self care or home management tasks. More therapy sessions were imperative due to this delay in services early in this patient's treatment. Also any delay in services during the appeal process would cause more loss in function and in ROM. The patient had an HEP for motion but this would not be enough for him to regain functional use of the left hand. This patient was at risk for further surgery if additional motion and strength were not achieved.

On February 7, 2011, an appeal for additional OT was denied with the following rationale: *"I spoke to, the occupational therapists. The patient has limited motion of shoulder and elbow. ODG would support up to 16 visits over eight weeks. The patient has undergone 37 physical therapy sessions to date. The clinician has not described the clinical necessity for ongoing formal therapy at this point versus an aggressive home exercise program. Therefore, based on the clinical information submitted for this review and using the evidence-based, peer reviewed guidelines, this request for occupational therapy 3 x wk x 6 wks for the left wrist, hand, and shoulder is not certified."*

On February 14, 2011, Dr. noted the patient had been doing some HEP with pulleys and making excellent progress. His pain in the shoulder was much better. He still had mildly limited ROM with internal rotation but he was doing much better. His forearm really did not have pain. He had been doing some gentle lifting. He did not have much recovery of his ulnar nerve function but overall he felt he was doing fine. Examination of the left shoulder showed forward flexion to 170 degrees, abduction 145-150 degrees, external rotation to 75 degrees and internal rotation up to L2. There was full ROM of elbow without pain. Interosseous wasting persisted and there was no sensory function of the ulnar nerve and there was not FTP function of the ulnar nerve distribution. X-rays of the left forearm showed callus to be maturing, dorsal callus, and beginning to fill in a little bit. There was some callus on the medial and lateral sides as well as volarly and dorsally. Dr. recommended continuation of the bone stimulator for additional two months giving him a full six months on stimulator and follow-up after that time. As regards to the shoulder, he stated the shoulder function was definitely acceptable at this point. He recommended resuming activities as tolerated and slowly getting back into light duty work activities as tolerated. Continuation of PT at home was recommended.

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

As of the 2/4/11 office visit with Dr., it appears that his impression and clinical findings do not correlate with those of Ms.. Dr. gives no indication as to why surgery would be necessary if additional PT/OT was not approved, contrary to the statement of Ms.. Dr. noted that shoulder function was acceptable, and this

is supported by the examination findings. Additional OT for the hand and/or elbow does not appear indicated.

It appears that the preauthorization reviewers opined in accordance with the documented clinical findings vis-à-vis ODG.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES