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### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 04/22/11

**IRO CASE #:**

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

Occupational therapy for the right hand three times a week for four weeks to consist of CPT codes 97110, 97140, 97035, and G0283

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

Board Certified in Orthopedic Surgery  
Fellowship Trained in Hand 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)

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.

Occupational therapy for the right hand three times a week for four weeks to consist of CPT codes 97110, 97140, 97035, and G0283 - Upheld

#### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations with M.D. dated 01/03/11, 01/17/11, 02/07/11, 02/28/11, and 03/28/11

A therapy evaluation with O.T.R. dated 03/02/11

Preauthorization requests from D.O. dated 03/03/11 and 03/10/11

A letter of non-certification for occupational therapy to the hand, according to the Official Disability Guidelines (ODG), from M.D. dated 03/08/11

A letter of non-certification for occupational therapy, according to the ODG, from M.D. dated 03/17/11

The ODG Guidelines were not provided by the carrier or the URA

#### **PATIENT CLINICAL HISTORY**

On 01/03/11, Dr. recommended a cock-up wrist splint and work restrictions. On 01/17/11, Dr. recommended a CT scan of the right hand with continued splinting. On 02/07/11, Dr. reviewed the CT scan that showed diffuse arthritic changes and

subchondral cysts in the bones. On 02/28/11, Dr. recommended continuation of the wrist splinting, as well as some hand therapy. On 03/02/11, Ms. recommended therapy two to three times a week for four weeks. On 03/08/11, Dr. wrote a letter of non-certification for the occupational hand therapy. On 03/17/11, Dr. also wrote a letter of non-certification for the hand therapy. On 03/28/11, Dr. recommended an NCV study and weaning from the wrist splint.

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

This patient was given a diagnosis by the treating physician, Dr., of carpal tunnel syndrome and hand pain. Specifically, based on the latest note dated 03/28/11, she stated there was no weakness with manual muscle testing and that the patient had full digital range of motion, but had some decreased wrist range of motion. This would be very unusual for the presentation of carpal tunnel syndrome. In addition, therapy is not normally recommended in the normal treatment of carpal tunnel syndrome per the ODG. Furthermore, for a crushing injury to the hand or finger, the ODG recommends nine visits over eight weeks. I do not believe that the current physical therapy being requested falls in line with ODG and therefore, the requested occupational therapy for the right hand three times a week for four weeks to include CPT codes 97110, 97140, 97035, and

G0283 is neither reasonable nor necessary. The previous adverse determinations should be upheld at this time.

**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 AND KNOWLEDGE BASE
- 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)