

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: November 27, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8 Occupational Therapy Visits for the Right Wrist, 2 Times a Week for 4 Weeks as Outpatient

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

This physician is Board Certified in Orthopedic Surgery with over 40 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

08-27-13: History and Physical Exam
09-10-13: History and Physical Exam
09-18-13: UR performed
09-25-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a long history of pain, weakness, swelling and numbness in both hands and forearms. Most of the pain is worse while at work. Arm pain onset was noted for work comp as xx/xx/xx. She was treated with thumb braces, ibuprofen and an unknown injection. She received two physical therapy visit and discontinued it because her pain was so bad.

08-27-13: History and Physical Exam for bilateral hand pain. It was reported a note was reviewed neurologist, who diagnosed ill defined myofascial pain on both arms diffusely, ill defined paresthesias, NCV mild cubital tunnel. Physical exam:

Right Hand/Wrist: The hand and wrist have no visible abnormal swelling, but the patient felt as if her arms were swollen. There tenderness diffusely volar and dorsal hands and forearms. Wrist ROM is normal and painless, thumb ROM is normal, patient would not actively make full fist which was unexplainable as there was not significant swelling. There was no weakness in the hand intrinsic muscles and wrist and hand manual muscle testing. No sensory deficits in the hand and fingers. Tinel sign positive. Left Hand/Wrist: Tenderness diffusely dorsal and volar hands and wrists and forearms. ROM is normal. No weakness present. Sensory exam normal. Tinel sing was normal. X-rays: Right and Left Hand: maintained joint space, no dislocation, subluxation or fracture and no arthritic changes noted. EMG/NCV: 8-8-13: Mild cubital tunnel. Assessment: Arm pain. Plan: Patient said PT made her pain much worse which is unusual. Will try a different OT for nerve glides. Will change splints from thumb spica to regular cock up splints. Prescribed Mobic.

09-10-13: History and Physical Exam. Assessment: PT was very guarded on both UE from fingers to the shoulders. PT had anxiety and stress about her symptoms and was visibly upset about her status. Explained she needed to relax otherwise she could aggravate the symptoms. She requires skilled therapy to address: edema, pain, decreased function, decreased ROM, decreased strength , symptoms of irritated nerves, information about body mechanics, ergonomic, and posture. Plan: OT for 4 weeks.

09-18-13: UR performed. Rationale for Denial: When noting the lack of a specific compensable event, the long history of ill-defined complaints, the lack of a specific diagnosis and that the physical examination reports of complaints in excess of any objective parameter, and noting thus prior physical therapy made the symptoms worse, there is no clinical indication that occupational therapy would have any efficacy. Therefore, when noting the official disability guidelines treatment plan parameters outlined below, this request is not medically necessary.

09-25-13: UR performed. Rationale for Denial: The request is not reasonable or medically necessary. The claimant has had minimal rather inexplicable progress to formal supervised therapy, residual deficits should be addressed with a self-administered therapy protocol especially in the light of the marked discrepancies between subjective complaints and objective findings. Susan had no further information to add.

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

The previous adverse determinations are upheld. Based on the records reviewed, there is no indication for further PT or OT. The claimant discontinued PT after only 2 visits due to pain. There is no indication that OT would be any different. There is documentation of complaints in excess of objective findings. Therefore, the request for 8 Occupational Therapy Visits for the Right Wrist, 2 Times a Week for 4 Weeks as Outpatient is not found to be medically necessary.

PER ODG:

Physical/
Occupational
therapy

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. ([Handoll-Cochrane, 2003](#)) ([Handoll2-Cochrane, 2003](#)) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. ([Handoll-Cochrane, 2002](#)) ([Handoll-Cochrane, 2006](#)) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy (p<0.05). ([Rapoliene, 2006](#)) Active Treatment versus Passive Modalities: See the [Low Back Chapter](#) for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).

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 carpal bone (wrist) (ICD9 814):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of metacarpal bone (hand) (ICD9 815):

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

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

Dislocation of finger (ICD9 834):

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

Trigger finger (ICD9 727.03):

Post-surgical treatment: 9 visits over 8 weeks

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Synovitis and tenosynovitis (ICD9 727.0):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Mallet finger (ICD9 736.1)

16 visits over 8 weeks

Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):

Post-surgical treatment: 12 visits over 8 weeks

Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):

Post-surgical treatment: 18 visits over 6 weeks

Ulnar nerve entrapment/Cubital tunnel syndrome (ICD9 354.2):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Sprains and strains of wrist and hand (ICD9 842):

9 visits over 8 weeks

Sprains and strains of elbow and forearm (ICD9 841):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

Open wound of finger or hand (ICD9 883):

9 visits over 8 weeks. See also [Early mobilization](#) (for tendon injuries).

Post-surgical treatment/tendon repair: 24 visits over 16 weeks

Pain in joint (ICD9 719.4):

9 visits over 8 weeks

Arthropathy, unspecified (ICD9 716.9):

Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

Amputation of thumb; finger (ICD9 885; 886):

Medical treatment: 18 visits over 6 weeks

Post-replantation surgery: 36 visits over 12 weeks

Amputation of hand (ICD9 887):

Post-replantation surgery: 48 visits over 26 weeks

Work conditioning (See also [Procedure Summary](#) entry):

12 visits over 8 weeks

Carpal tunnel syndrome (ICD9 354.0):

Medical treatment: 1-3 visits over 3-5 weeks

Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks

Post-surgical treatment (open): 3-8 visits over 3-5 weeks

Crushing injury of hand/finger (ICD9 927.2 & 927.3):

9 visits over 8 weeks

Contusion of upper limb (ICD9 923)

6 visits over 3 weeks

Crushing injury of upper limb (ICD9 927)

9 visits over 8 weeks

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 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)**