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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/27/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: outpatient right hand MUA wrist & right hand

A 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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. It is this reviewer's opinion that medical necessity is not established for the requested outpatient right hand MUA wrist & right hand

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy report dated 03/26/13
Clinical report dated 05/02/13
Postoperative physical therapy progress report dated 06/06/13
Postoperative physical therapy progress report dated 07/29/13
Prior reviews dated 04/24/13 & 05/16/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who sustained an injury on xx/xx/xx after she sustained a right humeral shaft fracture. The patient did attend physical therapy but continued to report pain in the right upper extremity. Prior electrodiagnostic studies were stated to show evidence of a right ulnar nerve neuropathy at the elbow as well as a C6-7 radiculopathy. The clinical evaluation on 05/02/13 demonstrated loss of range of motion of the dorsal capsules from 15 to 30 degrees. There was improvement in the radial nerve function with some persistent pain present. It was felt that the patient had plateaued in regards to physical therapy for the digits of the right hand. A therapy progress report on 06/06/13 again demonstrated loss of range of motion in the upper extremity at the right shoulder, right elbow, and right wrist. There was also moderate weakness present. The patient was reported in having improved response to therapy and was recommended to continue with postoperative physical therapy. Follow up on 07/29/13 stated the patient continued to have improvements in right elbow range of motion. There were also improvements in range of motion of the right wrist on extension and in the right shoulder and elbow. Strength was somewhat improved at this evaluation. The patient was recommended to continue with postoperative physical therapy.

The request for manipulation under anesthesia of the right wrist and hand was denied by

utilization review on 04/24/13 as therapy reports demonstrated slow progress with the therapy and that further manipulation under anesthesia would not provide meaningful relief of the patient's symptoms.

The request was again denied by utilization review on 05/16/13 as guidelines do not recommend manipulation under anesthesia for the hand or the wrist as there are no peer reviewed journals supporting this procedure.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient continues to report loss of range of motion in the right upper extremity at the shoulder, elbow, and wrist. The patient is noted to be improving albeit slowly with physical therapy and it does not appear that the patient has reached a plateau with therapy. The patient's physical therapy reports continued to recommend additional physical therapy. As there are no indications that the patient has reasonably exhausted or plateaued with physical therapy and as guidelines do not recommend the use of manipulation under anesthesia procedures in the right wrist and hand due to lack of evidence within clinical literature supporting its efficacy as compared to standard physical therapy or exercise programs, it is this reviewer's opinion that medical necessity is not established for the requested outpatient right hand MUA wrist & right hand and the prior denials are upheld.

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)