



**MEDICAL EVALUATORS
OF TEXAS** ASO, L.L.C.

1225 North Loop West • Suite 1055 • Houston, TX 77008
800-845-8982 FAX: 713-583-5943

Notice of Independent Review Decision

DATE OF REVIEW: January 7, 2014

DATE AMENDED: February 10, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational Therapy 8 additional sessions

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

This case was reviewed by a board certified Orthopaedic Surgeon currently licensed and practicing in the State of Texas.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Type of Document Received	Date(s) of Record
OT note	11/19/2013
Therapy Communication/Order Form	11/26/2013
An initial adverse determination letter	12/09/2013
A pre-authorization request for continued OT	12/11/2013
A second adverse determination letter	12/18/2013
An IRO request for denied services of "OT 8 additional sessions"	12/30/2013

EMPLOYEE CLINICAL HISTORY [SUMMARY]:



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This is a male sustained fracture of his left index finger on xx/xx/xx. There was no documentation regarding the mechanism of injury. He subsequently underwent ORIF of left index finger DIP fracture. An OT progress note dated 11/19/2013 indicates left index finger AROM is MP 80, PIP 95, and DIP 50. A note dated 11/26/2013 indicates that PIP joint was sore and sensitive (though getting better). Grip strength has increased to 10 lbs and now 115-120 lbs. Pinch strength (3-point) was 8 lbs left versus 18 lbs right. An initial denial letter dated 12/09/2013 indicates had completed 17 postop sessions of supervised rehab. An appeal request dated 12/11/2013 by OTR indicates there was 30 degrees difference in ROM of involved and uninvolved digit. Functional pinch strength was significantly limited in left with 2-point averaging 5.6 lbs as compared to 18.3 lbs average for right upper extremity and 3 point-pinch strength averages 8 lbs on left as compared to 18.3 lbs on right. There is a request for continued occupational therapy for progressive desensitization and strengthening (particularly pinch strength) as well as manual therapy techniques to decrease joint stiffness to allow for full ROM.

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

This male continues to lack significant ROM and pinch strength. The letter written dated 12/11/2013 clearly outlines his lack of motion, decreased pinch strength and hypersensitivity, which interferes with his ability to use his hand normally in functional tasks. ODG limits post-surgical treatment to 16 visits over 10 weeks. However, ODG also states "more visits may be necessary when grip strength is a problem, even if range of motion is improved." The occupational therapist letter dated 11/26/2013 outlines his primary symptoms to be hypersensitivity, a well know complication of finger trauma. It also was noted that he was having pain and edema on 11/26/2013. ODG will allow 26 visits over 16 weeks for pain (chronic) that can provide short term relief during the early phases of acute pain treatment or acute exacerbations of chronic pain and are directed at controlling symptoms such as pain, inflammation and swelling.

ODG Criteria – Forearm, Wrist, & Hand - Online Version 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)



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

Minor, 8 visits over 5 weeks

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

ODG Criteria – Pain (chronic) - Online Version

Physical medicine treatment

Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of acute pain treatment or acute exacerbations of chronic pain and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include



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exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) As far as medical necessity considerations for exercise equipment, see the Knee Chapter, Durable medical equipment (DME), & the Low Back Chapter, Exercise. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):

26 visits over 16 weeks



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**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)