



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

[Date notice sent to all parties]:

01/13/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 x wk for 4 wks left wrist

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

Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:

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

X 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:

Cover sheet and working documents

Follow up note dated 03/28/13, 04/11/13, 05/09/13, 08/22/13, 10/17/13

Progress evaluation dated 10/04/13

Functional capacity evaluation dated 09/11/13

Re-evaluation dated 06/19/13

Initial evaluation dated 05/02/13

Utilization review determination dated 11/04/13, 11/15/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. X-rays revealed a fracture of

the distal radius. The patient underwent ORIF left radial styloid on 04/01/13. Initial evaluation dated 05/02/13 indicates that pain is rated as 8/10. On physical examination left wrist AROM is flexion 50, extension 30, RD 0, UD 10, supination 5 and pronation 30 degrees. Re-evaluation dated 06/19/13 indicates the patient has completed 12 physical therapy visits. On physical examination left wrist range of motion is flexion 53, extension 10, RD 10, UD 10, supination 45 and pronation 50 degrees. Functional capacity evaluation dated 09/11/13 indicates that the patient meets the material handling demands for a heavy demand vocation. Visit note dated 10/04/13 indicates that pain is rated as 5/10. Wrist range of motion is pronation 50, supination 55, RD 5, UD 20, extension 35 and flexion 20 degrees.

Initial request for PT 3 x week x 4 weeks left wrist was non-certified on 11/04/13 noting that the patient has completed 3 months of postoperative physical therapy and 10 visits of work conditioning. Official Disability Guidelines state that physical medicine treatment should be an option when there is evidence of a musculoskeletal or neurological condition associated with functional limitations that are likely to respond to skilled physical medicine treatment. When treatment duration and/or number of visits exceed the guideline recommendations, exceptional factors should be noted. Postsurgical treatment following fracture of the radius or ulna includes 16 visits over 8 weeks. There are no significant functional gains or exceptional factors noted following the initial course of physical therapy to warrant the need for a continuation of therapy at this time. There is no indication as to why this patient would not benefit from a home exercise program at this time. An additional 12 sessions of therapy added to the previous course completed exceeds guideline recommendations for a postsurgical treatment of 16 visits. The denial was upheld on appeal dated 11/15/13 noting that while continued PT may be considered, the requested number of visits in addition to the completed sessions already exceeds the guideline recommendations. With more than substantial number of therapy visits provided, the patient should have been fully progressed into an independent exercise program at this time.

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

Based on the clinical information provided, the request for PT 3 x week for 4 weeks left wrist is not recommended as medically necessary. The patient underwent ORIF left radial styloid on 04/01/13 and has completed 12 postoperative physical therapy visits as well as 10 work conditioning sessions to date. The Official Disability Guidelines Forearm, Wrist and Hand Chapter supports up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

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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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Forearm, Wrist and Hand Chapter

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) (Handoll-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

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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):

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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