

**DATE: 06/10/14**

Notice of Independent Review

**DATE NOTICE SENT TO ALL PARTIES: 06/10/14**

**IRO CASE #:**

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

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering the consequences of a wrist fracture

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

Occupational therapy two times per week for eight weeks and neuromuscular electrical stimulation G0283

**REVIEW OUTCOME:**

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

- X** Upheld                      (Agree)  
 Overturned                      (Disagree)  
 Partially Overturned              (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
813.23	97110		Prosp.				Xx/xx/xx		Upheld
813.23	97140		Prosp.				Xx/xx/xx		Upheld
813.23	97112		Prosp.				Xx/xx/xx		Upheld
813.23	G0283		Prosp.				Xx/xx/xx		Upheld

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

**PATIENT CLINICAL HISTORY (SUMMARY):**

The claimant is a female who suffered injury to her right wrist in a fall on xx/xx/xx. She was initially treated with closed reduction and splinting. Subsequent evaluations resulted in open reduction and internal fixation of this comminuted Colles fracture of the right wrist. Postoperatively, she was prescribed occupational therapy and had completed at least five sessions. She has persistent pain and persistent diminished range of motion prior to the conclusion to her primary course of occupational therapy. A request has been submitted for additional occupational therapy to a total of an additional sixteen sessions. Included is a request for electrical stimulation as an unsupervised modality as part of the exercise program. The initial consideration of this request for additional occupational therapy was denied; it was reconsidered and denied.

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

The current request, if performed, exceeds the recommended course of physical therapy in the ODG 2014. The recommended course of occupational therapy in the postoperative period subsequent to open reduction and internal fixation of Colles fracture of the right wrist is approximately sixteen sessions over eight weeks. The unsupervised modality of electrical stimulation is also not a recommended modality for physical

therapy or occupational therapy as part of the treatment protocol. The previous denial was appropriate, reconsideration was appropriate, and the denial should be upheld.

**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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)