

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

[Date notice sent to all parties]:

01/08/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Occupational Therapy 2 x week and 4 weeks left index finger and left long finger

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Board Certified Orthopedic and Hand Surgery

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.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. The patient sustained fracture dislocation, extensor tendon injuries and partial amputation. The patient underwent ORIF P1 fracture left index and long finger, P2 fracture left long finger, left index finger PIP joint dislocation, PIP joint dislocation left long finger, repair extensor digitorum communis of the left index and long fingers on xx/xx/xx. The patient subsequently underwent left index finger extensor tenolysis, PIP joint capsulotomy, tenolysis of flexor digitorum profundus and flexor digitorum superficialis, and removal of cerclage wire on 07/17/14. Designated doctor evaluation dated 10/01/14 indicates that the patient is complaining of stiffness of the left index and long finger and he cannot use these two fingers. He has slight numbness there. He is not working. He had a second surgery with only slight improvement. He has had 12 sessions of physical therapy since then. The patient was determined to have reached maximum medical improvement as of 10/01/14.

The designated doctor did not feel that he is going to improve significantly with any further surgery or any further treatment. The patient was given 14% whole person impairment. Follow up note dated 12/01/14 indicates that the long finger is greatly improved. The MCP joint is normal at 0 and 90 degrees. PIP joint is 0 and approximately 45 degrees and DIP joint is 0 and 5 degrees. The index finger MCP joint is normal. PIP joint is 0 and approximately 15 degrees, very stiff and painful. The DIP joint is 0 and 15 degrees.

Initial request for occupational therapy 2 x week x 4 weeks left index finger and left long finger was non-certified on 11/20/14 noting that measurable objective findings were not noted to corroborate reported improvement or to compare with previous findings to establish objective functional improvement. The patient has completed 30 postoperative occupational therapy visits which exceed the guideline recommendations and there was no evidence of exceptional factors to warrant additional visits. The denial was upheld on appeal dated 12/05/14 noting that the patient has completed 30 postoperative visits to date which exceed the guideline recommendations for post-surgical treatment for his conditions. It was noted he has residual functional deficits; however, objective range of motion and motor strength values were not included with the recent documentation to verify this. There was also no additional evidence of significant objective functional improvement with recent therapy that would justify the need for additional physical therapy visits.

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 occupational therapy 2 x week and 4 weeks left index finger and left long finger is not recommended as medically necessary, and the two previous denials are upheld. The patient underwent left index finger extensor tenolysis, PIP joint capsulotomy, tenolysis of flexor digitorum profundus and flexor digitorum superficialis, and removal of cerclage wire on 07/17/14 and has completed 30 postoperative therapy visits to date. The Official Disability Guidelines support up to 24 sessions of occupational 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 was determined to have reached maximum medical improvement by a designated doctor as of 10/01/14. The designated doctor did not feel that he is going to improve significantly with any further surgery or any further treatment. 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.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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) (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):

10 visits over 4 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