Notice of Independent Review Decision

Case Number:  Date of Notice: 01/19/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Occupational Therapy 2 X 6

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)

Patient Clinical History (Summary)

The patient is a female who slipped and fell on XX/XX/XX suffering a fracture of the base of the 5th metacarpal. The patient underwent a 5th CMC fusion of the left hand with open reduction and pinning of a 4th metacarpal base fracture on XX/XX/XX. The patient was seen postoperatively for occupational therapy in XXXX. The patient was being followed postoperatively. The last clinical report noted ongoing complaints of pain in the left hand which was mild at 2/10 in intensity. The patient did describe issues with range of motion with minimal improvements following therapy. The XX/XX/XX report did consider MMI and impairment versus a 2nd opinion with another surgeon. The patient’s physical examination noted flexion and extension of the wrist to 60 degrees. Grip strength was decreased to clinical testing. There was some loss of range of motion in the fingers of the left hand. The patient was recommended to continue with a formal physical therapy program.

The requested therapy was denied by utilization review on XX/XX/XX as there were no exceptional factors to support further therapy versus a home exercise program.

The request was again denied on XX/XX/XX as additional occupational therapy would be excessive based on prior therapy and there were no further findings to support exceeding guideline recommendations.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has been followed for persistent pain in the left hand following surgery in XX/XXXX. The patient had undergone prior occupational therapy in XXXX. The last evaluation available for review was from XX/XXXX which noted some loss of grip strength in the left hand and a mild amount of restriction on range of motion of the fingers. The patient did have good range of motion in the left wrist. No further evaluations of this patient were available for review noting any exceptional factors to support continuing with a formal physical therapy program versus a home exercise program. Any additional physical therapy or occupational
therapy at this time would reasonably exceed guideline recommendations without exceptional factors noted. Therefore, it is this reviewer’s opinion that medical necessity for the request has not been established at this time and the prior denials remain upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ACOEM-America College of Occupational and Environmental Medicine knowledgebase
- AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic Low Back Pain
- Interqual Criteria
- 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-Official Disability Guidelines and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and 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)