Clear Resolutions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

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

Board Certified Orthopedic Surgery

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

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XX XX is a XX who was diagnosed with pathological dislocation of the right hand (M24.341), stiffness of the right hand (M25.641), pain in the joints of the right hand (M25.541), effusion of the right hand (M25.441), and generalized muscle weakness (M62.81). On XX, XX was allegedly struck XX that fell from XX and striking XX in the ankle. XX sustained injury to the right knee and ankle as well as the right ring finger with fractured ribs in the right thoracic region.

On XX, XX was seen by XX MD for pain in the right hand / wrist and right knee. XX right finger continued to swell. Orthopedics gave XX a silicone sleeve to help with the swelling. XX was to wear it throughout the day. It was tender to touch and continued to hurt by moving. Overall, the symptoms had decreased at the right ring finger and there was moderate improvement in flexion. Numbness and tingling remained the same. There was occasional tingling in the right ring finger. XX grip strength had increased, and the swelling had decreased. Bruising had resolved. The pain was 0/10 at rest and 10/10 if XX bumped it. XX stated overall the symptoms in the right knee had decreased. The pain was 0/10, but if XX tried to work on XX knee, it would go up to 4/10. There was some pain with squatting and swelling. On right hand / wrist examination, edema was reduced and the bruising had resolved. There was decreased range of motion of the right ring finger, especially with extension, but improved to flexion. XX could flex XX distal interphalangeal joint a little bit more. The muscle testing revealed a weak grip strength and extension strength continued to be weak. Decreased strength to flexion and extension of the right ring finger was noted. On the right knee examination, the strength remained the same. Flexion and extension returned to normal. Tenderness and effusion had resolved.

Per a physical therapy / occupational therapy internal communication note dated XX XX OTR documented that XX had completed 20 sessions of occupational therapy for the right hand. XX reported significant pain in the proximal interphalangeal (PIP) joint past 70 degrees. XX progress might be limited by the significant increase in XX proximal interphalangeal joint with a passive motion past 70 degrees.

The treatment to date included 20 sessions of physical therapy / occupational therapy, home exercise program, silicon sleeve, and surgical intervention.

A Physician Advisor Determination was completed by XX, MD on XX. The requested service was occupational therapy 8 units for the right ring finger, which included 97530, 97110, 97140, 97032, 97018, 97150, 97010 (re-evaluation 97168 did not require precertification). The decision was modified to 4 sessions consisting of 97530, 97110, 97140, 97018, 97150, and 97010. Clinical Rationale: “Absent the opportunity to speak with the requesting physician / provider, the request as written must be non-certified. The request meets criteria for 4 additional sessions. Modalities of ultrasound and electrical stimulation are not authorized. Other modalities are authorized not to exceed 4 units per session. Office agreed to modification per URN.”

Per a Physician Advisor Determination dated XX, the requested service of occupational therapy visits including CPT codes of 97168, 97530, 97110, 97140, 97032, 97018, 97150, and 97010 was non-certified by XX, MD. Clinical Rationale: "Absent the opportunity to speak with the requesting physician / provider."

Per a Physician Advisor Determination dated XX, the prior decision for the requested service was upheld by XX, MD. All medical documentation was reviewed and the requested services were denied. Rationale: "Occupational therapy 4 visits 97530, 97110, 97140, 97032, 97018, 97150, 97010. Evaluation code 97168 does not require precertification. The injured worker has persistent pain of the proximal interphalangeal joint of the right ring finger. Examination revealed a decreased range of motion. XX has had 20 prior occupational therapy (OT) visits with functional improvement. There is limited documentation of a specific functional deficit or functional treatment goal to be addressed by additional treatment. There were no reasons provided why a prescribed independent home exercise program would be insufficient to address any remaining functional deficits. Rationale for other than a prescribed and self-administered protocol is not evident at this time. Therefore, the additional visits are not indicated as medically necessary at this time".

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

The documentation available indicates a total of 20 therapy sessions have been completed prior to the request for eight additional sessions. Partial certification for four additional sessions was recommended by the initial provider. The second provider reviewed for the remaining four additional sessions which were not authorized. Noncertification of the sessions was also advised. The ODG supports the use of physical therapy following injuries to the forearm, wrist, and hand. Guidelines would recommend up to maximum of 16 therapy sessions following the injury. When noting that a total 24 sessions has been requested, this would exceed guideline recommendations and further deviation from the guidelines would not be supported based on the clinical information available for review. As such, the prior partial authorization for four sessions would be not indicated. Regarding the specific CPT codes, the provider appropriately identified that the ultrasound and electrical stimulation would not be supported. Given the documentation available, the requested service(s) is considered not medically necessary.

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
- ☐ AHRQ-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
- ☑ 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

Forearm wrist and hand chapter
Physical/ Occupational therapy

Recommended.
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.

Fracture of carpal bone (wrist):
Medical treatment: 8 visits over 10 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of metacarpal bone (hand):
Medical treatment: 9 visits over 3 weeks
Post-surgical treatment: 16 visits over 10 weeks
Fracture of one or more phalanges of hand (fingers):
Minor, 8 visits over 5 weeks
Post-surgical treatment: Complicated, 16 visits over 10 weeks
Dislocation of finger:
9 visits over 8 weeks
Post-surgical treatment: 16 visits over 10 weeks

☐ 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.