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December 18, 2017

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Twelve sessions of occupational therapy for the right wrist

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

Board Certified in Orthopedic Surgeon
Diplomate of the American Board of Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Twelve sessions of occupational therapy for the right wrist – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX performed a right Guyon's canal release on XXXX. As of XXXX, XXXX had some soreness around the incision site, but overall was doing well. XXXX still had some weakness of the fingers, but XXXX had improvement in XXXX sensation. Sutures were removed and XXXX was referred to therapy for orthoses and ulnar nerve exercises. The patient was evaluated in occupational therapy on XXXX. XXXX had limited range of motion of the right wrist and digits. Occupational therapy 3 times a week for 4 weeks was recommended at that time by XXXX. The patient then attended occupational therapy from XXXX through XXXX, at which XXXX reevaluated XXXX. XXXX continued with weakness in XXXX ring and small fingers and had been attended therapy 3 times a week. XXXX

sensation and strength were improving. Continued therapy was recommended, which XXXX attended on XXXX through XXXX for 4 more sessions. XXXX reevaluated the patient on XXXX. XXXX had moderate hypersensitivity in XXXX right wrist and additional therapy 2 times a week four 4 weeks was recommended. As of XXXX, XXXX had improved sensation along the right small and ring fingers without signs of compartment syndrome. Continued therapy was recommended and a compressive glove would be added. Another referral for therapy 1-3 times a week for 4 weeks was submitted that day. A precertification request was then submitted on XXXX, requesting 12 sessions of occupational therapy, as well as a compression glove. The patient also received therapy on XXXX. XXXX reported XXXX right small and ring fingers were numb and XXXX had weakness of the right hand. On XXXX, XXXX provided an adverse determination for the requested 12 sessions of occupational therapy for the right wrist. Another precertification request was submitted on XXXX for 12 sessions of occupational therapy. XXXX and XXXX addressed a Letter of Medical Necessity on XXXX, noting objective progress had clearly been demonstrated and continued therapy for an additional month was again recommended. As of XXXX, XXXX noted the patient had not been going to therapy because it was denied and XXXX had improvement when XXXX was going. It was felt XXXX had intrinsic hand weakness and reduced grip strength and required additional therapy. XXXX range of motion was improving, but XXXX still had a minimal claw hand. Twelve additional sessions were again recommended. On XXXX, XXXX provided another adverse determination for the requested 12 sessions of occupational therapy for the right wrist. On XXXX, the patient informed XXXX was doing home exercises, but additional therapy had been denied. XXXX complained of numbness, tingling, and pain to XXXX right 4^{th} and 5^{th} fingers. XXXX was noted to still have hand atrophy and additional therapy was recommended. XXXX also wrote a letter of medical necessity that day for additional therapy. On XXXX addressed a letter and reviewed the patient's history. Additional occupational therapy was felt to be necessary and appropriate.

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

The patient is a XXXX who reportedly developed a right Guyon canal lesion and reportedly had undergone two separate surgical procedures. The first procedure was performed on XXXX and specific details were not available in the information reviewed. The second was on XXXX and performed by XXXX. XXXX has completed at least 30 sessions of formal occupational therapy based on the documentation provided for review. The last 20 were postoperative for the second procedure. The evidence based Official Disability Guidelines (ODG) recommend a maximum of 20 sessions of occupational therapy over 10 weeks status post Guyon canal release. The patient, according to occupational therapy notes, has made improvement, but still has weakness. It is unclear what XXXX functional status was prior to the first procedure and after the second procedure. The request was non-certified on initial review by XXXX on XXXX. XXXX non-certification was upheld on reconsideration/appeal by XXXX on XXXX. Both reviewer attempted peer-to-peer, but were only able to speak to the therapist. Both physicians cited the ODG as the basis of their opinions.

The patient has not demonstrated significant improvement in XXXX grip strength to date, based upon the reviewed therapists' notes. The evidence based ODG recommends fading of treatment, which has not been performed, and it is unclear what type of home exercise program the patient, if any, has actually been engaged in. The patient is over five months status post second surgical intervention. XXXX appears to have plateaued with current treatment and it is unclear what functional gains, if any, further occupational therapy would offer. It would have been anticipated that strengthening would have been a significant component of XXXX rehabilitation at this point in XXXX treatment plan. Therefore, the requested 12 sessions of occupational therapy for the right wrist are not medically necessary, reasonably related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

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**

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

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **ODG- OFFICIAL 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)**