INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

07/02/2018

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
12 sessions of occupational therapy left wrist

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopedic 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 XX XX whose date of injury is XX. The patient fell XX and sustained a fracture of the left distal radius. The patient underwent ORIF left distal radius on XX. Occupational therapy re-evaluation note dated XX indicates that diagnoses are closed Barton's fracture of left radius and decreased range of motion. Pain is rated as 0/10. Left wrist AROM is flexion 40, extension 45, radial deviation 20, ulnar deviation 25, pronation 70 and supination 45 degrees. Strength is 4/5. As of this date the patient had completed initial evaluation and 8 treatments with fair clinical improvement. The initial request was non-certified noting that it is not clear how much physical therapy has been completed, and there is no current clinical assessment by the treating surgeon demonstrating the efficacy or utility of the therapy. The denial was upheld on appeal dated XX noting that the clinician evaluation of XX did not recommend additional physical therapy, and specifically stated additional physical therapy was not indicated and that the claimant was to continue with a self-directed home exercise program. The patient has achieved improved range of motion. Strength should continue to improve with use of a home exercise program.

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 12 sessions of occupational therapy left wrist is not recommended as medically necessary. The patient underwent ORIF left distal radius on XX and has completed at least 9

postoperative therapy visits to date. Current evidence based guidelines support up to 16 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

IRO REVIEWER REPORT TEMPLATE -WC

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)**

Official Disability Guidelines Treatment Index, 23nd edition online, 2018-
Forearm, Wrist and Hand Chapter updated 05/09/18

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.

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):

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

Fracture of radius/ulna (forearm):

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 16 visits over 8 weeks

Dislocation of wrist:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

Dislocation of finger:

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

Trigger finger:

Post-surgical treatment: 9 visits over 8 weeks

Radial styloid tenosynovitis (de Quervain's):

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Synovitis and tenosynovitis:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Mallet finger:

16 visits over 8 weeks

Contracture of palmar fascia (Dupuytren's):

Post-surgical treatment: 12 visits over 8 weeks

Ganglion and cyst of synovium, tendon, and bursa:

Post-surgical treatment: 18 visits over 6 weeks

Ulnar nerve entrapment/Cubital tunnel syndrome:

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Sprains and strains of wrist and hand:

9 visits over 8 weeks

Sprains and strains of elbow and forearm:

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

Open wound of finger or hand:

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:

9 visits over 8 weeks

Arthropathy, unspecified:

Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks

Amputation of thumb; finger:

Medical treatment: 18 visits over 6 weeks

Post-replantation surgery: 36 visits over 12 weeks

Amputation of finger without replantation: 14 visits over 13 weeks

Amputation of thumb without replantation: 16 visits over 3 weeks

Amputation of hand:

Post-replantation surgery: 48 visits over 26 weeks

Post-amputation treatment: without complications, no prosthesis: 18 visits over 17 weeks

Post-amputation treatment: with complications, no prosthesis: 24 visits over 22 weeks

Amputation of arm:

Post-amputation treatment: without complications, no prosthesis: 18 visits over 17 weeks

Post-amputation: without complications, with prosthesis: 30 visits over 27 weeks

Post-amputation: with complications, no prosthesis: 30 visits over 22 weeks

Post-amputation: with complications and prosthesis: 40 visits over 35 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 4 weeks

Carpal tunnel syndrome:

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:

9 visits over 8 weeks

Contusion of upper limb:

6 visits over 3 weeks

Crushing injury of upper limb:

9 visits over 8 weeks

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).