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**Reviewer's Report**

**DATE OF REVIEW:** 4/12/18
**IRO CASE #:** XXXXXX

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
Eight occupational therapy sessions (two times a week for four weeks).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
M.D., Board Certified in Physical Medicine and Rehabilitation.

**REVIEW OUTCOME**
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

☒**Upheld** **(Agree)**

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

I have determined that the requested eight occupational therapy sessions (two times per week for four weeks) is not medically necessary for the treatment of the patient's medical condition.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The patient is a XX who was injured on XXXX. The patient was XX with a result of displaced right metacarpal neck fracture with multiple bone fragments. The patient underwent an open reduction of the right index finger metacarpal neck fracture with associated collateral recess pinning on XXXX. The occupational therapy reevaluation note from XXXX noted that the patient does remain with limited functional use of XX affected hand and significant pain rated at 5/10. On XXXX, the records noted that the patient was XX status post surgery due to work-related injury. Wrist flexion was 45 degrees, which had improved from 35 degrees, wrist extension was 45 degrees, which had improved from 40 degrees, radial deviation was 15 degrees which remained the same as previous, ulnar deviation was within normal limits and was previously 22 degrees. Right index finger metacarpophalangeal joint range of motion was 0/45, which had improved from 10/35, proximal interphalangeal joint improved from 0/45 to 10/55. Grip strength improved from 23 to 35, lateral pinch improved from to 8 to 12 and three-point pinch improved from 5 to 7. The patient was noted have pain and tenderness along the metacarpophalangeal joint of the affected right index finger. It was noted that the patient was demonstrating improved wrist and digital active range of motion. However, the patient remained with notably limited in index finger flexion and activity tolerance with the affected hand when

compared to norms. A requested has been submitted for eight occupational therapy sessions (two times per week for four weeks).

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

The Official Disability Guidelines recommend 16 visits over 10 weeks following surgical treatment for a fractured metacarpal bone. The documentation provided indicates that the patient has received at least XX occupational therapy visits. The request exceeds guideline recommendations. There was no indication of any exceptional factors to warrant the need to exceed guideline recommendations. As such, the requested an occupational therapy sessions 2 times a week for 4 weeks is not medically necessary.

Therefore, I have determined the requested eight occupational therapy sessions (two times per week for four weeks) is not medically necessary for treatment of the patient's medical condition.

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**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**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

1. Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Forearm, Wrist and Hand, Physical/ Occupational Therapy.

- ☐ **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)**