Applied Independent Review

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An Independent Review Organization

09/24/2018

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

Description of the service or services in dispute:
Occupational therapy for the XX hand and finger

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)

Patient Clinical History (Summary)
This case involves a now XXXX with a history of an occupational claim from XXXX. The mechanism of injury was fracture XX finger while doing XXXX. The current diagnosis is documented as unspecified contracture. Ambulatory assessment report dated XXXX through XXXX the patient reported XX hand was pain free at rest, painful when bumped. Treatment plan modalities included hot packs, cryotherapy, ultrasound, electrical stimulation /XX/ XX, paraffin. Treatment plan procedures included Passive range of motion, active range of motion exercise, strengthening exercises, manual therapy techniques, body mechanics, body mechanics, posture training. Reported on examination XX hand range of motion active, interphalangeal thumb flex XX. Patient had been treated with outpatient occupational services since XXXX on the XX hand which was dominant. Patient has completed XX sessions of occupational therapy sessions. The patient had increased active range of motion RIF, continued to be unable to make a complete composite fist for grasping, physical therapy has met partial goal at this time. Prospective Review (XX) Response dated XXXX Occupational therapy for the XX hand and finger non-certified because there was no additional documentation that would support going outside the guidelines for additional formal therapy.

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

Official Disability Guidelines is being cited as the primary source as it provides specific evidence that is directly related to the treatment being requested for the patient's condition. Official Disability Guidelines indicate Physical/ Occupational therapy is a recommended treatment for fracture of phalanges of hand was 8 visits over 5 weeks. There was documentation that the patient had increased active range of motion to the XX XX finger and also will complete remaining goals when 8 visits were completed. No documentation why the patient needs additional sessions of occupational therapy. As such, the request for Occupational therapy for the XX hand and finger is not medically necessary and therefore 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 um knowledgebase
- ☐ 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 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 Médical **Literature** (Provide a description)

Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)