

CPC Solutions
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Notice of Independent Review Decision

Review Outcome:

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

X

Description of the service or services in dispute:

X

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)

Information Provided to the IRO for Review: X

Patient Clinical History (Summary)

The patient is a X whose date of injury is X. The patient fell on this date. The patient underwent ORIF left intraarticular distal radius fracture and left carpal tunnel release on X. Claim review notes that the claimant was approved for X postop to date. The patient is diagnosed with right 5th base metacarpal fracture, bilateral finger stiffness, left distal radius fracture, and left acute carpal tunnel syndrome. Follow-up visit report dated X notes that the claimant is status post open reduction and internal fixation of left intraarticular distal radius fracture and right fifth metacarpal base fracture. The claimant has been attending occupational therapy and reports slow improvements. The claimant can gently flex and extend fingers, but the claimant cannot flex small finger into palm. There is tightness noted at small finger, but distal phalangeal joint and proximal interphalangeal joint are supple. There is moderate edema noted. The claimant's wrist range of motion is measured at supination to 50 degrees, pronation to 70 degrees, extension to 60 degrees and flexion to 12 degrees. The provider recommends weight bearing as tolerated to left upper extremity. Occupational therapy plan of care note dated X reports that the claimant is not working due to non-weight bearing status. The claimant rates of pain at 3/10 currently and ranges from 3/10 at best to 5/10 at worst. The left wrist range of motion is measured at flexion to 30 degrees, extension to 20 degrees, and radial deviation/ulnar deviation to 10 degrees. The left thumb metacarpophalangeal joint flexion is noted at 50 degrees and interphalangeal joint flexion is noted at 59 degrees. The Extension of left index finger at metacarpophalangeal joint is -15 degrees, proximal interphalangeal joint is -10 degrees, and distal phalangeal joint is 0 degrees. The extension of left middle finger at metacarpophalangeal joint is -15 degrees, proximal interphalangeal joint is -20 degrees, and distal phalangeal joint is 0 degrees. Office visit note dated X indicates that the patient is unable to make a full fist with the left hand. X has not attended formal occupational therapy in the last 3 weeks. Left wrist range of motion is supination 88, pronation 62, extension 10 and flexion 22 degrees. X-rays of the left wrist show well aligned intraarticular distal radius fracture with volar plate and screws in place. There is restoration of radial height, radial inclination and volar tilt. No other fracture seen through the carpus. No signs of hardware loosening or failure.

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 X, is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that, “X, ODG guideline recommends X. The guideline recommends X. Continued therapy may be indicated when all of the following are present, functional progress has been made during initial therapy or the plan of care has been modified or re-evaluated every 2-3 weeks, maximum improvement has not yet been attained, the patient is actively participating in treatment sessions and the patient is adherent to the plan of care. In this case, the claim review notes that the claimant was approved for X postop to date. The claimant has already completed and exceeded the recommended course of skilled care per guideline, and additional X would further exceed the guideline. After over X, it is expected that the claimant would be independent in a home exercise program and at-home modality used to manage the current condition. Thus, the request for X is not medically necessary. The request is denied.” The denial was upheld on appeal noting that, “The request for appeal X is not recommended medically necessary. The ODG recommends up to 9 visits of occupational therapy for hand fractures, 8 visits of postoperative therapy following carpal tunnel release, and 16 visits of postoperative therapy following the surgical treatment of distal radius fractures. The provided documentation indicates the worker sustained injuries to the right hand and left wrist/hand with a right 5m metacarpal fracture and left distal radius fracture and carpal tunnel syndrome. The distal radius fracture and carpal tunnel syndrome were treated with surgery on X. The worker has reportedly completed X for the left wrist and bilateral hands. The provider has recommended X and although some ongoing range of motion deficits are appreciated, there is no evidence that the worker is unable to address these with a home exercise program. It is documented the worker is performing a home exercise program and using dynamic static devices to assist with range of motion. There is no evidence that these measures have failed to lead to progress and there is no evidence of why these measures cannot be continued. There are no findings that support exceeding the guideline recommendation. As such, the request for appeal X is not medically necessary.” There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent ORIF left intraarticular distal radius fracture and left carpal

tunnel release on X. Claim review notes that the claimant was approved for X to date. The request for X exceeds guidelines and also does not allow for adequate interim follow-up to assess the patient's response to treatment and adjust the treatment plan accordingly. When treatment duration and/or number of visits exceed 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.

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
- Internal Criteria
- Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards

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- 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
- TMF Screening Criteria Manual

- Peer Reviewed Nationally Accepted Medical **Literature** (Provide a description)

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

