

# P-IRO Inc.

An Independent Review Organization

835 E. Lamar Blvd., #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 866-328-3894

## IRO REVIEWER REPORT TEMPLATE -WC

---

**DATE OF REVIEW:** DECEMBER 19, 2007

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Speech therapy X 24 visits

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

MD, Board-certified in Internal Medicine and Specialized in Occupational Medicine

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

No ODG Guidelines

Dr., October to November 2007

Dr., January to July 2007

Denial Letters 11/1/07 and 12/3/07

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant sustained a traumatic brain injury. He underwent hemicraniectomy for evacuation of a subdural hematoma. He received a course of speech therapy that ended in May 2007. The progress notes indicate he was improving with this treatment. Current physical examination shows impairment of speech with expressive aphasia. The claimant has been recommended for 24 additional sessions of speech therapy.

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

The Reviewer has reviewed the applicable guidelines and the peer-reviewed medical literature concerning the use of speech therapy in the treatment of traumatic brain injuries. This claimant has speech deficits that have improved with previous therapy, though he still has significant impairment. The claimant has demonstrated significant, objective improvement in his speech deficits with past therapy. It is within a reasonable degree of medical probability that he would benefit from the proposed course of therapy.

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
- 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
- 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)**