

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 23, 2007

IRO CASE

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of occupational therapy (97110, 97140, 97035, 97018) 3X week X 4 weeks

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in orthopedic surgery and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
813.44	97110, 97140, 97035, 97018		Prosp	12					Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

TDI-HWCN-Request for an IRO-16 Pages

Respondent records- a total of 24 pages of records received to include but not limited to: letter, 6.14.07, 6.27.07; Notes, Orthopedic Surgery Grp, 3.26.07; notes, Therapy, 3.27.07-6.11.07

Requestor records- a total of 32 pages of records received to include but not limited to: notes, Therapy, 3.27.07-6.08.07

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient has had a very extensive injury involving the upper extremity. The development of stiffness, swelling, and pain is an expected outcome of this injury. The patient has had appropriate occupational therapy thus far, with documented improvement in function, yet incomplete improvement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

ODG Guidelines were reviewed and simply state an average number of visits based upon a general diagnosis and are not specific to individual patients. These guidelines regarding occupational therapy were not based on peer-reviewed evidence-based medicine specific to this patient's injury and anticipated complications. They were based on "consensus," which is not evidence based in this specific patient. It is not peer reviewed literature applicable to this specific patient.

There is no credible scientific study which provides evidence that occupational therapy in a patient with this degree of injury, who has had demonstrated improvement, should be denied continuing treatment. In this individual patient, the requested treatment is neither excessive nor inappropriate. Necessary medical care in this specific patient is not being safeguarded. Since evidence-based medicine on this individual patient in terms of actual numbers of visits is not available, the treatment request follows generally accepted standards of medical practice recognized in the medical community.

It is appropriate care, since the patient has demonstrated improvement and should continue until the patient has failed to demonstrate improvement. It is not reasonable, at this time, to assume that the patient can manage this extensive injury on her own. Therefore, all of the requested treatment is deemed as medical necessary.

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
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)