IRO America Inc.
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Phone: 512-266-5815
Fax: 512-692-2924

DATE OF REVIEW:
JUNE 25, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Occupational therapy, 12 visits, three times weekly for four weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board-certified Internal Medicine, Specialty Physical Medicine and Rehab

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including:
Multiple physical therapy notes.
Electrodiagnostic testing, May 2007.
Dr., xx/xx/xx.
Dr. May 2007.
Dr. May 2007.

PATIENT CLINICAL HISTORY [SUMMARY]:
The Patient sustained an open fracture of the right distal humerus with ulnar nerve involvement. This required two surgeries to correct. He has undergone post-operative physical therapy. Multiple physicians have documented persistent deficits in range of motion and strength due to the injury.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.
The Patient sustained a significant injury to the right elbow, requiring operative intervention. He continues with objective functional deficits, measured by multiple providers, despite physical therapy. Occupational therapy is designed specifically to restore strength and function to upper extremity injuries. Twelve

sessions offers the best possibility to improve the Patient's condition and aid his recovery from his injury. Thus, the Reviewer disagrees with the determination of the insurance carrier and has determined that the therapy is medically 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
- ☒ 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)