

IRO America Inc.

An Independent Review Organization
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DATE OF REVIEW:

MAY 24, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Left Humerus OT

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

M.D. Board Certified Orthopedic Surgeon

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

Left shoulder MRI, 12/09/06
Office notes, Dr., 01/11/07 and 03/01/07
Occupational therapy notes, 12/13/06, 12/21/06, 01/10/07 and 01/31/07
Therapy referral, 01/11/07 and 03/19/07
Utilization review, Dr., 02/14/07
Functional capacity evaluation, 03/13/07
Utilization review, Dr., 03/28/07
Letter regarding medical dispute resolution, 05/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This female sustained a left humerus fracture and underwent ORIF. There was also a diagnosis of radial nerve palsy and left shoulder pain and weakness. MRI of the left shoulder was done and demonstrated a small subacromial spur with a minimal subacromial subdeltoid bursitis. The claimant was undergoing therapy for the shoulder, elbow, hand and wrist. Left shoulder flexion was 115 and abduction 72. Left elbow flexion was 135 and extension -47. The claimant had decreased MCP motion of the fingers.

Dr. documented left elbow stiffness and numbness in the hand. She still had numbness in the hand dorsally and weakness of the wrist and fingers. The shoulder was improving. She had weakness of the wrist. Sensory exam was unchanged. The left humerus was noted to be healed. She had stiffness of the elbow. The claimant continued therapy apparently for a total of 24 visits.

On 01/11/07 the claimant had left shoulder flexion to 150 degrees, passively another 10. Elbow motion was 35-130. The claimant had 2+/5 strength in wrist extension. EMG/NCS on 01/02/07 showed acute severe radial neuropathy involving all the radial innervated muscles with some degree of median neuropathy. On 01/11/07 continued therapy was ordered to keep the hand and wrist supple while the nerve regenerates. The claimant had plateaued with motion of the elbow.

Therapy was denied on a 02/14/07 Utilization review. On 03/01/07 the claimant had elbow motion 15-135. She was not able to extend her wrist and fingers. She had give-way weakness on strength testing for the radial nerve. Dr. felt occupational therapy would be beneficial for her fingers and hand. Therapy was denied again on utilization review.

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

Having reviewed the information above, this claimant would have been expected to achieve the maximal benefit from the formal therapy provided. At this late date, the Reviewer does not believe that formal therapy would make any functional difference for the patient. As such the Reviewer agrees with the determination of the Insurance Carrier that the services should be denied and would not consider the additional requested occupational therapy to be 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

2007 Official Disability Guidelines, 12th edition, Integrated with Treatment Guidelines (ODG Treatment in Workers' Comp, 5th edition). Shoulder: fracture of humerus - 18 visits over 12 weeks

- 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)