

C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW:
MAY 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional physical therapy, twelve sessions (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

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, and Treating Doctor (s), including:

M.D.,
Carrier Correspondence
Carrier Denial Letters 3/28/07, 5/1/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient developed pain in the right upper extremity while packing. X-rays were normal. She was treated with a course of physical therapy (unclear the exact number of sessions, but it appears to be 11 or 12) with no improvement

(VAS 8/10 at beginning and end of treatment). Physical examination shows tenderness at several areas in the affected extremity.

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

The Patient has sustained a soft tissue injury of the right upper extremity. Reasonable treatment would consist of nine physical therapy visits over eight weeks. The patient has already exceeded this number with no objective or subjective improvement. Rationale is not provided as to why this patient might benefit from further treatment. There is little chance that additional therapy would provide clinical benefit. Thus the Reviewer agrees with the determination of the Insurance Carrier.

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)