

# Clear Resolutions Inc.

An Independent Review Organization  
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**DATE OF REVIEW:** OCTOBER 11, 2007

**IRO CASE #:**

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

Occupational Therapy, 2 times a week for 4 weeks, right forearm.

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

MD, 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)

*The reviewer finds that Occupational Therapy, 2 times a week for 4 weeks, right forearm is not medically necessary.*

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 8/13/07, 9/20/07  
Official Disability Guidelines and Treatment Guidelines  
Medical notes from MD – op report 5-8-07, office notes 4-20-07 to 10-9-07  
Therapy Discharge summary and exercise log  
Therapy notes 7-16-07 to 8-7-07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

*The injured employee suffered a deep laceration to the volar proximal forearm and underwent fasciotomy, flap closure and recession of 2 cutaneous nerves.*

*He has plateaued in therapy and the surgeon is recommending a free gracilis muscle flap to improve function.*

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

*This is a complex case. However, the surgeon feels that the patient has plateaued from therapy and does not feel that further therapy is indicated. He currently recommends a free gracilis muscle flap to improve function. The reviewer agrees that therapy notes and progress reports indicate that the patient has plateaued in therapy and the ODG Guidelines do not support further therapy as indicated at this time. In conclusion, the reviewer finds that Occupational Therapy, 2 times a week for 4 weeks, right forearm is not 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)

**GREEN'S OPERATIVE HAND SURGERY**

- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)