

MEDICAL REVIEW OF TEXAS

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Notice of Independent Review Decision

AMENDED 3/19/08

DATE OF REVIEW: MARCH 14, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational Therapy sessions x 12

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

MD, Board Certified in Family Practice

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

- * Non-certification notice per Dr. 2/11/08 with ODG Guidelines
- * Appeal denied 2/20/08 with ODG Guidelines
- * Paperwork
- * Therapy notes from 3/12/07 – 1/31/08
- * Progress notes and letter from Dr. from 11/6/06 to 1/2/08
- * Chest x-ray report [11/7/07]
- * Lab results from 11/29/06, 12/14/06, 8/31/07, 11/7/07
- * Notes from Dr. (cardiologist) from 12/14/06 to 1/2/08
- * CT angio report [12/21/06]

- * CT thoracic report [12/21/06]
- * EKG on 8/30/07 and additional one undated

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained a shoulder injury. He was treated with medications. Eventually he had surgery 10/8/06. Patient was treated with medications, extensive therapy, and off work. He had a CABG in 1/07 unrelated to injury. He continued with therapy and medications. He underwent another surgery in October 2007. He had postoperative therapy again. Two requests for additional therapy were denied.

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

PATIENT SUSTAINED THE ORIGINAL INJURY. HE HAD TWO SURGERIES; THE LAST BEING OCTOBER 2007. HE HAD EXTENSIVE THERAPY OVER THE TIMEFRAME OF HIS INJURY AND TREATMENT RECORDS SUBMITTED DO NOT JUSTIFY OR SHOW MEDICAL NECESSITY FOR FURTHER SUPERVISED THERAPY.

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**

X 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)**