

Notice of Independent Review Decision

DATE OF REVIEW: 9/2/2008
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational therapy 3 times per week for 4weeks (97110, 97014, 97018)

QUALIFICATIONS OF THE REVIEWER:

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 2006 and Pain Management since 2006.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Occupational therapy 3 times per week for 4weeks (97110, 97014, 97018) Upheld

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This injured employee is a xx year old female diagnosed with a closed fracture and stiffness of joint in the left index finger due to a device that fell on it on xx/xx/xx. She has already undergone 8 sessions of therapy and reports some improvement in range of motion. The provider is recommending continued occupational therapy to the left hand.

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

Based on the clinical documentation provided, the previous denial of additional therapy sessions is upheld. The right handed injured worker suffered fractured left index distal phalanx on xx/xx/xx. The injured worker has completed the ODG recommended 8 sessions of OT to date. The injured worker has improved but still has limited range of motion per the office note on 7/11/08. However, there are no objective measures of range of motion or strength measure to support medical necessity of additional therapy. Additionally, there is no mention of HEP being incorporated by the injured worker with a goal to replace skilled therapy. The request for additional OT is not considered medically necessary and therefore the previous denial is upheld.

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)