



DATE OF REVIEW: 03/05/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OF SERVICES IN DISPUTE:

Occupational therapy, seven visits over 60 days.

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients having suffered upper extremity injuries

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. ZRC forms
2. TDI referral forms
3. Denial letters, 12/09/08 and 01/12/09
4. URA records including clinical notes, 01/05/09, 11/26/08
5. Occupational therapy prescription and evaluation, 11/24/08, 11/26/08
6. Occupational therapy progress notes, 12/03/08
7. Memo dated 01/14/09
8. ODG criteria, physical therapy and occupational therapy

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient is a female with apparently two injuries. The first date of injury was xx/xx/xx. She fell, suffering a fracture of the distal radius and ulna. Manipulative pinning was performed, and apparently the fracture healed. She then underwent a number of occupational therapy sessions, possibly as many as 40. The original injury was to her right wrist. Subsequently approximately xx later in xx/xx, the patient fell

again, suffering another injury to the same wrist. This injury is not well documented. There is no documented physical examination or x-ray report. Additional physical therapy has been requested in the form of occupational therapy. The request for additional therapy has been evaluated and denied, and it has been reconsidered and denied. There is little, if any, documentation to specifically justify the additional occupational therapy.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

The medical documentation of this patient's original injury, original treatment, original post injury physical therapy and then subsequent injury is insufficient to have a full understanding of the patient's current status. There is no documentation of the current range of motion or disabilities. The patient has received as much physical therapy as can be justified. Additional physical therapy/occupational therapy is neither justified, nor can it be approved.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)