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Notice of Independent Review Decision

DATE OF REVIEW: 11/17/09

IRO CASE #:

Description of the Service or Services In Dispute
Physical therapy 3 x wk x 4 wks w chiropractic manipulation

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

Physician Board certified in Physical Medicine and Rehabilitation

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)

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

Adverse determination letters, 9/14/09
Office notes, Dr. 9/15/09, 8/4/09, 7/8/09
Pre authorization request 8/20/09
Evaluation form 8/7/09
FCE 9/23/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who in xx/xxxx fell on his outstretched hand, injuring his wrist. In July 2009 he sought medical treatment. X-rays were negative, and he was treated with bracing, injections and occupational therapy. He underwent physical therapy for his shoulder. A 9/23/09 FCE rated the patient as functioning at a light physical demand level. He is a teacher and his current work status is not in the records provided for this review.

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

I agree with the denial of the requested physical therapy. The patient sustained injury to the left wrist. He has undergone occupational therapy for the wrist and physical therapy for the shoulder. No documentation regarding his progress was provided for this review. There is no medical documentation explaining the need for further physical therapy. The patient has already undergone therapy and the medical necessity for physical therapy is not established in the records submitted for review.

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)**