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**Notice of Independent Review Decision**

**DATE OF REVIEW: 10/7/11, amended 10/11/11**

**IRO CASE #**

Description of the Service or Services In Dispute

Left Wrist: Occupational Therapy, Ultrasound Therapy, Manual Therapy, each 2x wk; 5 wks

**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, 9/9/11, 8/23/11

Reconsideration request 8/8/11

Ortho Office and physical therapy notes (clinical and visits) 8/5/11 - 6/27/10, voluminous

Radiology & Lab Reports, Medical Center, 5/25/11 - 7/20/10

Operative reports, 6/1/11 – 7/28/10

ODG Guidelines

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who tripped and fell in xx/xxxx, and sustained a left distal radius fracture. She underwent open reduction on 7/28/2010 with hardware. She underwent extensive physical therapy and rehabilitation through June 2011. Surgery to remove hardware was performed on 6/1/2011. She has been receiving physical therapy through August 2011.

Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision.

I agree with the benefit company's rationale and decision to deny the requested service.

A previous reviewer noted that there hasn't been reasonable progress with the large number of clinic physical therapies. And I agree with the reconsideration report dated 9-9-11. The patient has had at least 60 supervised therapy sessions since the injury. And she also has had therapy since the last surgery. No intervening significant problems have arisen. Further therapy likely would be not helpful, and therefore not justified, and is not called for by ODG guidelines.

**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)**