

SENT VIA EMAIL OR FAX ON
Sep/06/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Sep/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational Therapy 2 X wk X 5 wks left upper arm and shoulder

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

orthopedic surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 08/08/11, 08/17/11
3. Upper extremity reevaluation dated 08/02/11, 03/14/11, 02/09/11, 06/22/11, 05/10/11, 01/17/11
4. Treatment encounter notes
5. Shoulder flow sheets
6. Appeal letter dated 04/26/11
7. Office visit note dated 03/03/11, 04/07/11, 03/18/11, 02/16/11, 03/07/11, 01/25/11, 01/04/11, 12/21/10, 12/14/10
8. EMG/NCV dated 03/03/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient fell down some stairs and sustained a left humeral head fracture. The patient was placed in a fixator sling and subsequently transitioned to a less restrictive sling. EMG/NCV dated 03/03/11 revealed electrical diagnostic evidence for a moderate left median mononeuropathy of the wrist. The patient completed at least 10 sessions of occupational therapy. Upper extremity reevaluation dated 08/02/11 indicates that pain is rated as 4/10 (same). Range of motion of the left shoulder is flexion 130, extension 78, abduction 116, IR 62 and ER 92. Strength is rated as 4 to 4+/5.

Initial request for additional occupational therapy was non-certified on 08/08/11 noting that current evidence based guidelines support up to 8 sessions of OT for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient should be capable of continuing to improve with a home exercise program. The denial was upheld on appeal dated 08/17/11 noting that there is no clear documentation of the number of therapy visits completed to date and if this is a request for additional therapy where there has been recent therapy and there are remaining functional deficits, or additional therapy where there has been no recent therapy and there is a noted interval injury or objective exacerbation with functional regression.

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

Based on the clinical information provided, the request for occupational therapy 2 x wk x 5 wks left upper arm and shoulder is not recommended as medically necessary, and the two previous denials are upheld. The patient completed at least 10 sessions of occupational therapy between January and March 2011. There is no documentation provided to indicate whether the patient has undergone any recent therapy or if there has been an exacerbation of the injury. The patient's compliance with a home exercise program is not documented. As stated by the initial reviewer, there are no exceptional factors of delayed recovery documented to support exceeding the Official Disability Guidelines. Given the current clinical data, the requested occupational therapy is not indicated as medically necessary.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES