

Wren Systems

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
occupational therapy 3 times a week x4 weeks

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

M.D., Board Certified General Surgery; Fellowship trained Orthopedic Hand and Upper Extremity 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

Official Disability Guidelines and Treatment Guidelines
Utilization review determinations, 01/27/12, 01/12/12
Notes, 12/02/11, 01/04/12, 12/28/11, 01/13/12, 01/06/12, 01/03/11, 11/08/11, 12/12/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was working on an (approximately 480 volts) when an electric arch occurred. The patient sustained second and third degree flash flame electrical burns of 25% percent total body surface area. The patient underwent bilateral hand and upper extremities superficial thickness skin graft surgery on 08/17/11 and 08/31/11. The patient has completed over 36 occupational/physical therapy visits to date. Progress note dated 01/04/12 indicates that there is slight decline in range of motion in most of the digits and wrist. There is minimal improvement in grip and pinch, which affects activities of daily living.

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

This patient is noted to be status post skin grafting surgery x 2. He has completed at least 36 therapy visits to date. The Official Disability Guidelines support up to 16 visits for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. There are no specific, time-limited treatment goals provided. The patient's compliance with a structured home exercise program is not documented. The reviewer finds that medical necessity is not established for occupational therapy 3 times a week x4 weeks.

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

ACOEM-AMERICA 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)