

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jul/08/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

OT 3x6 Left Hand

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

Board Certified General Surgery

Fellowship: 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:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 06/19/13, 06/25/13

NCS study dated 03/25/13

Referral form dated 05/17/13, 02/15/13

Re-evaluation dated 05/03/13, 06/03/13

Office note dated 02/15/13

OT progress report dated 06/25/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was caught in a hydraulic gate. He stated the door drug him and he fainted. He sustained rib fractures, punctured lung, liver and injured an intestine. He dislocated his left arm. The patient has undergone multiple surgeries to the left arm. Electrodiagnostic study dated 03/25/13 revealed electrical evidence of severe median and radial nerve palsies as well as moderate to severe ulnar nerve palsy. OT progress report dated 06/25/13 indicates that the patient's last therapy visit was 06/19/13. Patient has been making good progress in therapy. He demonstrated increased left upper extremity AROM against gravity, increased strength and decreased forearm hypersensitivity.

Initial request for OT 3 x 6 was non-certified on 06/19/13 noting that surgical history included an exploratory laparotomy of the left upper extremity and ORIF of left humeral fracture no 09/20/12. The clinical notes do not evidence how many session of occupational therapy the patient has attended status postoperatively for this injury. Additionally, the current request was submitted with multiple passive treatment modalities to include contrast bath therapy, massage therapy, paraffin bath therapy and hot/cold packs which are not supported by

guidelines. Documentation of objective functional improvement with postoperative occupational therapy interventions was not evidenced. The denial was upheld on appeal dated 06/25/13 noting that diagnostic studies were not provided in the medical records. The guidelines detail the recommendation for no more than 4 treatment modalities per session to allow the physical therapist to focus on those treatments where there is evidence of objective functional improvement. Guidelines recommend active versus passive treatment modalities as they are associated with substantially better clinical outcomes. The request exceeds the recommended guidelines for the maximum recommended number of modalities per session as well as for active versus passive treatment modalities.

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

The patient sustained injuries in xx/xxxx. The patient reportedly underwent multiple surgeries to the left arm as well as occupational therapy; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There are no operative reports provided, and it is unclear how many sessions of occupational therapy the patient has completed to date. As such, it is the opinion of the reviewer that the request for OT 3 x 6 left hand is not recommended as medically necessary.

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)