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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE NOTICE SENT TO ALL PARTIES:** Nov/10/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Occupational therapy 18 visits

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for occupational therapy 18 visits is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is not described. Plan of care dated 08/19/14 indicates the patient has completed 9 therapy visits and has 7-8 remaining scheduled visits from her authorized therapy visits. She has made good progress thus far, reporting decreased pain and a gradual increase in range of motion. On physical examination right shoulder range of motion is flexion 150, extension WNL, abduction 150 and external rotation 60 degrees. Plan of care dated 10/02/14 indicates patient has been compliant with therapy visits and her home exercise program. Progress is noted to be slow but steady. Right shoulder range of motion is flexion 140, extension not tested, abduction 125, adduction WNL, internal and external rotation not tested. Initial request for occupational therapy 18 visits was non-certified on 09/17/14 noting that operative notes and progress notes from the treating clinician have not been provided. Additionally, a more recent progress note indicating the patient's response to the initial 18 authorized therapy visits has not been noted. The denial was upheld on appeal dated 10/16/14 noting that there is no indication of definite functional improvement secondary to physical therapy received in the past noted in records available for review. Comparing motion values in the note 09/09/14 and those in the note 10/02/14 essentially no improvement is described. Pain levels appear to be remaining the same.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained unknown injuries on xx/xx/xx due to an undisclosed mechanism of injury. It appears that the patient has undergone surgery; however, no operative reports are submitted for review documenting the nature and extent of surgical intervention. The patient has completed at least 18 visits of therapy to date without significant improvement documented. There is no clear rationale provided to support additional supervised therapy at this time, and the submitted records indicate that the patient is compliant with a home exercise program. Without additional information, medical necessity cannot be established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for occupational therapy 18 visits is not recommended as medically necessary and the prior denials are upheld.

**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)