

C-IRO Inc.

An Independent Review Organization

1108 Lavaca, Suite 110-485

Austin, TX 78701

Phone: (512) 772-4390

Fax: (512) 519-7098

Email: resolutions.manager@ciro-site.com

DATE NOTICE SENT TO ALL PARTIES: Apr/12/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Occupational therapy x 12 visits

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD Board Certified Family Medicine

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 x 12 visits is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury is XX/XX/XX. The patient's foot slipped between the truck and loading dock and he fell landing on both hands and forearms equally. Note dated XX/XX/XX indicates that he has been doing a home program, but hasn't heard about whether he is going to be doing PT. He reports improvement. Office visit note dated XX/XX/XX indicates that the patient complains of bilateral hand and wrist pain. Assessment notes contusion of bilateral hands and tendonitis. It is reported that the patient reports he is 90% improved and ready to return to work. He will continue with his home exercise program while on the road. Progress report dated XX/XX/XX indicates that the patient has completed 10 visits of therapy. On physical examination range of motion of the fingers is within normal limits. Progress note dated XX/XX/XX indicates that his pain is improving slowly, but he continues to have pain. On physical examination there is pain with dorsiflexion of the right wrist that is sharp in nature and is felt along the dorsum of the hand and proximally up the forearm. His grip strength is affected by this pain and is significantly diminished. The left hand is pain free.

Initial request for occupational therapy x 12 visits was non-certified noting that there is documentation of normal range of motion in the affected body region. Previous treatment is documented to have included at least 10 sessions of supervised rehabilitation services. Appeal letter dated XX/XX/XX indicates that he has been progressing slowly and has been working light duty for the last several weeks. He travels for work and is only in town occasionally to do his physical therapy. The denial was upheld on appeal dated XX/XX/XX noting that the patient has previously received 10 occupational physical therapy visits. The request exceeds guideline recommendations. There is no indication of any exceptional factors to warrant the need to exceed the guidelines recommendations. There was no documentation of the most recent physical examination of the patient's continued objective functional deficits.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient injured the bilateral hands as the result of a fall on XX/XX/XX. The patient reported that he was 90% improved and ready to return to work on XX/XX/XX. The patient has completed 10 visits of therapy to date. The Official Disability Guidelines support up to 9 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for occupational therapy x 12 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)