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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

X: Follow-Up Visit with X, MD
 X: Letter of Appeal from X, PT,DPT
 X: Request for Independent Review from X, MD
 X: UR by X, MD
 X: UR by X, DO
 Utilization Management Referral

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a X-year-old X that was injured on the job on X. While working at X, X was involved in an X, resulting in X. X residual injuries include X.

X: Follow-Up with Dr. X. Pt is here s/p X and X. X is getting OT thru Dr. X surgeon. X had been getting PT but it has ended. X has been progressing with PT and X. Now able to stand from chair by X without assistance. X X is not functional and tends to land by X. X is able to X and can stand X. X is still having problems with X. X X coordination for X. X has X Patient explains the X to be date of occurrence. Pt reports the physical problem has severe impact and prevents normal activity. Medical History includes: X all.

X: Follow-Up. Pt's XX states X XX with a more X with XX XX, but X is forward flexed, using a b/l platform X. X X needs more assistance during X and X responds to cues to correct XX. X no longer XX during gait with wearing b/l XX. X is not approved for more therapies, but would benefit from a maintenance therapy program. XX feels X is regressing after no X. Pt is able to do activities at X level. X does try X XX. Pts XX are taking longer with increased weakness to X X. X states X X is almost healed. Plan: Request have been made for a maintenance rehab program to prevent further loss of strength and function with PT/OT. PT to evaluate height of platform RW. X

requires this program to meet goals and avoid functional decline. DME- XX XX XX for maintenance of XX XX strength and endurance for home use. X for XX. LE X.

X: Request from Dr.X. PT/OT/SLT for maintenance program to maintain current function with transfers and gait, continued work with XX and X contractures to increase functional use for bimanual tasks and ROM to prevent decline from disuse. LST to treat with ongoing strategies for X word finding XX deficits. Issues are that pt requires program to maintain X current mobility. X does not XX in the home unless X is with PT. X, pt's XX is able to assist with XX and all X ADLs, but if patient becomes weaker from immobility, then X is high risk for XX with potential for bony injury. This has already occurred in XX X, where pt was hospitalized for R X due to XX at XX. Pt uses X XX XX when X is XX with XX, otherwise X is in X.

X: UR by Dr.X. Rationale- In this case, the claimant sustained an X injury, resulting in multiple X, X, and multiple X X had been participating in therapy on an ongoing basis for rehab, in order to regain ROM and prevent decline. There were contractures and generalized weakness documented. The provider notes that additional therapy is being recommended. However, the request was submitted for evaluation and treatment, and the frequency and duration of the intended treatment was not specified. Also, the claimant had an extensive history prior to rehab, but there were no therapy notes provided or rehab summaries to identify specific improvements as a result of therapy. Given the above, the request is not supported.

X: UR by Dr X. Rationale- Based on the review of the extensive medical documentation, it is my opinion that the request is not medically necessary. This again plateaued in regard to improving strength or improving ROM. The ability to regain function that would actually improve X functionality is not reasonable, does not have reasonable expectations.

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

The previous adverse decisions are Upheld. The request does not specify

frequency, the request exceeds ODG recommendation for duration in regards to multiple diagnoses involving the X with X, X XX of X, and X surgery XX X, and clinically there is no documentation regarding progress with previous occupational therapy of the X particularly given more recent assessment that the X is "nonfunctional." There is notation that the request is for "maintenance" therapy so as not to lose strength and mobility. However, there is no documentation regarding instruction in and/or compliance with a X Program for the patient/claimant as well as X so as to maintain X. There is also question as to current disposition and consideration of X disposition such as X particularly given the extent, severity and chronicity of the case now X years since injury. This is significant information regarding goals/expectations of any request for therapy. Therefore, the request for X Therapy Evaluation of X, X Weeks (frequency unspecified), as Outpatient is considered not medically necessary.

PER ODG XX

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

- ACOEM- AMERICAN 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)**