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INFORMATION PROVIDED TO THE IRO FOR REVIEW:

TDI:

- Utilization review (X)
- Correspondence (X)
- Reconsideration (X)

Broadspire:

- PT (X)
- Office Visit (X)
- Correspondence (X)
- Utilization review (X)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a X-year-old X who was injured on X, when X was working with XX. X was involved in an X.

On X, the patient was seen at X reevaluation. On the X exam, the X range of motion (ROM) was X, X, X, X and X. The X was X, X, X and X. The DIP ROM was X, X, X, X, X. The X was X X test was X. During the X test, the patient required X with the X use and X. The patient had difficulty with

X as well as X. It was assessed X would benefit from skilled OT for improving X range of motion (ROM) and use of X X to assist self with activities of daily living. The diagnoses were X, X with X. The treatment was planned five times a week for eight weeks.

On X, the patient was seen at X reevaluation. The diagnoses X. The treatment was planned five times a week for eight weeks.

On X, the patient was seen by X, M.D. The patient had X. On exam, the patient had X. There were multiple healed X. There was larger X. The motor strength exam revealed X. The X strength was just traceable, but no X was noted. The X contractures. The X. The X was X. There was X. X difficulties were noted. The patient presented in a X could use X to assist with X, tended to X stand transfer. Stand to sit activity was XX. The diagnoses were X, X prescribed. X were recommended. X were also recommended.

On X, a correspondence by X, DPT indicated X filed an appeal on behalf of the patient. The patient had previously received X therapy services under the care of X, with subsequent evaluations performed on X, and X, by X services. The patient's previous bouts of X therapy were complicated by numerous X, limiting X ability to participate fully in skilled therapy services. The patient's evaluations performed on X, revealed continued X. However, X demonstrated functional improvement from X previous therapy evaluations and bouts of care. It was deemed the patient would benefit from X setting in order to improve X as well as improve independence and ease with all mobility related activities of daily living in order to improve quality of life and decrease XX burden at XX.

On X, the patient was seen by Dr. X. The patient reported no pain. X was status post X due to a XX injury in X. On exam, the patient had X The motor strength revealed X noted. The X contractures. The X. There was

X. X difficulties were noted. The patient presented in a X. No sit to stand was attempted. The other diagnoses were essential X and X without complications. X was recommended three to five times a week. X were prescribed.

On X, Dr. X believed the patient required a X to maintain X. X was not able to XX in the XX unless X was with X. The patient's X was able to safely assist with transfers and all X ADLs, but if the patient would become X, then X was at X with potential for X. This had already occurred in X, where the patient was hospitalized for X due to XX at X. The patient used X X with assistance otherwise X was in a X. The patient was referred to utilization management for the request of independent review organization (IRO).

On X, Dr. X completed a utilization review request for X
On X, X, M.D., completed a Utilization Review and denied the request for X based on the following rationale: "*The Official Disability Guidelines recommend X for patients with X. In this case, the patient sustained an X, resulting in X. X had been participating in therapy on an ongoing basis for rehabilitation, in order to regain range of motion and prevent decline. There were X and generalized X 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 intended treatment was not specified. Also, the claimant had an extensive history of prior rehabilitation, but there were no therapy notes provided or rehabilitation summaries to identify specific improvements as a result of prior therapy. Given the above, the request is not supported. X evaluation and treatment of the X, frequency and duration unspecified, as an outpatient was not medically necessary*."

On X, X notified Dr. X about the denial decision.

On X, a correspondence by Dr. X indicated the patient had been under care and continued to have X with a X. The patient had X and would benefit from an 8-to-12-weeks outpatient rehabilitation program to address X decline in functional ability to X and X, assist with X for ADLs and ongoing X. At the given time, X was unable to XX with the assistance of X alone and required XX XX to XX. Due to X X, X would always require XX for XX. The patient had been without any therapies and X had increasing difficulty with X. X was at risk for further X due to the nature of X injury.

On X, X, D.O., completed a reconsideration and denied the request for X, 8-to-12-weeks (frequency unspecified) as outpatient on the basis of following rationale: "Apparently, the patient's living situations are in a XX with X. X is unable to X. X method of XX is a custom manual X using the X platform. X does have a large X. Medical records indicate X is unable to X. X can hold a XX in X*, but X is not able to use X for any functional activities. X is on several medications X. X has been under the care of X. The patient has had extensive X and X therapy since X initial injury and according to the medical records reviewed, X functional capabilities have not improved in spite of the extensive physical and occupational therapy and in spite of the extensive treatment that X has had for X condition. The request at this time is essentially an extensive rehabilitation program involving all of X deficits and the medical records indicate that the qoal is to prevent further deterioration. Based on the review of the extensive medical documentation, it is my opinion that the request for reconsideration for X evaluation and treatment of the X,* 8-to-12-weeks *(frequency unspecified), as an outpatient, is not medically reasonable, necessary or appropriate. This again plateaued in regards to X. The ability to regain function that would actually improve X functionality is not reasonable, does not have reasonable expectations."*

On X, X notified Dr. X about the denied decision.

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

Medical records indicate X is unable to XX and requires XX with all of X XX of XX XX. X is not able to use X X for any functional activities. X has had extensive therapy from an injury dated X and three XX and appears the request is primarily to prevent decline. The past extensive therapy exceeds ODG, but there have been reasons to extend per Appendix D. However, given the fact X is X years post injury, dependent on X family for all X ADLs and has limited functional use of the X they should have been schooled in home therapy. The request for reconsideration for occupational therapy evaluation and treatment of the X, 8-to-12-weeks (frequency unspecified), as an outpatient, is not medically reasonable, necessary or appropriate. Improving function, strength, range of motion and/or function are not reasonable, does not have reasonable expectations.

☐ Medically Necessary

X Not Medically Necessary

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**