IRO REVIEWER REPORT - WC

DATE OF REVIEW: 04-16-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Preauthorization of work conditioning 5x/week for 2 weeks

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

Doctor of Chiropractic
Qualified Medical Examiner

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim Number	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld Overturn
		Prospective	847.0	97545	Upheld
		Prospective	847.0	97546	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Pre-authorization Determination (Denied) dated 03-15-07 and 03-30-07
Report of Medical Evaluation dated 01-03-07
Physician note with work conditioning/hardening prescription dated 01-25-07
Physician Reports dated 02-05-07, 02-23-07, and 02-26-07
Physician letter dated 04-10-07

Operative Report for procedure performed on 09-11-06
Functional Capacity Exam (FCE) dated 01-25-07 and 03-01-07
Review of Records note dated 03-12-07
Work Conditioning Exercise Program sessions (10) from 02-06-07 thru 02-22-07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant was injured when a ceiling fan fell while the blades were rotating, resulting in a cervical and shoulder injury. On 09/11/06, the claimant underwent Acromioplasty with debridement.

On 01-03-07, the claimant was evaluated and the claimant reported intermittent left shoulder pain that was rated 5/10, "neck is fine" and numbness and weakness. Examination reported tenderness in the anterior aspect of the left shoulder with no spasm. There was no tenderness with palpitation of the cervical, thoracic or scapula regions, supraspinatus, trapezius, elbows, wrists or hands. Range of motion (ROM) for the left shoulder was limited in extension, abduction, internal and external rotation. Range of motion for the cervical spine was full with no report of pain. Grip strength was unremarkable while muscle strength in the left shoulder was reported as 3/5 with no specificity as to which muscles. Neurological testing was unremarkable. An impairment rating was not offered as the claimant's anticipated date of maximum medical improvement is 03-11-07.

On 01-26-07, the FCE noted pain in the left shoulder reported as 7/10. No neck pain was reported. ROM for the left shoulder showed limitation in almost all planes by as little as ~40% and by as much as ~70%. External rotation exceeded the norm. Overall ranges were worse than from the time of the initial exam of 01-03-07.

On 02-05-07, the claimant was reported as presenting with pain, weakness and functional limitation of the left shoulder and it was noted the claimant was initiating a Work Conditioning program. No other findings were provided.

The note of 02-23-07 claimant is progressing in work conditioning.

On 02/26/07, the claimant was re-examined and the treatment plan included follow-up FCE and request additional ten visits of work conditioning.

On 03-01-07, a FCE noted pain in the left shoulder was reported as 5/10 with no report of neck pain. ROM for the left was mildly improved in some planes of motion since the 01-26 exam, while other planes showed no improvement or were worse. These ROM were overall worse than the initial exam of 01-03-07. Some findings provided in this FCE were so outside the clinical norm as to not make sense.

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

A number of issues are evident in the records that caused the Reviewer to question the need for the treatment proposed. The reports of 01-03, 01-25, 02-23, and 03-01-2007 make no mention of neck pain.

A review of the ROM findings of the left shoulder after completing 10 sessions of work conditioning are worse than when she was initially evaluated on 01-03-07. The only ROM that showed improvement was in external rotation, measured at 121°. Normal for this joint is 80° to 90°. To externally rotate to 120° would likely result in luxation of the shoulder. Hence, the Reviewer has to question the findings as an accurate depiction of the claimant's condition.

Exercises performed at the clinic such as "overhead tricep stretch" and "shoulder to overhead" box lifting would indicate a ROM that is greater than reported.

Mercy Guidelines state that if no significant improvement is achieved a referral should be sought or the patient should be examined for chronicity. The records reviewed do not show reasonable objective functional improvement. ACOEM Guidelines (pg. 43-45, 90-92, 113-115, 166 174, 175, 182, 188, 299-301 315) and the Official Disability Guidelines 10th Edition, state that if an individual's progress is not in relation to the extent or duration of the chiropractic or physical therapy services provided to achieve such progress or restoration, then those services are not considered reasonable or necessary.

In light of the findings noted above, the Reviewer determined that there is inadequate rationale to support continued work conditioning.

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

X **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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- X **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**