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Notice of Independent Review Decision

DATE OF REVIEW: 12-03-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Electrical Stimulation Therapy Left Shoulder 3xwk x 4wks
Paraffin Bath Therapy Left Shoulder 3xwk x 4wks
Ultrasound, Each 15 Minutes Left Shoulder 3xwk x 4wks
Additional Physical Therapy Left Shoulder 3xwk x 4wks
Massage Therapy Left Shoulder 3xwk x 4wks
Manual Therapy Techniques Therapy Left Shoulder 3xwk x 4wks

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

Certified by The American Board of Physical Medicine & Rehabilitation

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/ Overturn
		Prospective	840.4	97014 97035 97110 97113 97140 97530	12 12 12 12 12 12	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Non Certification of Service/Procedure 10-26-07 and 11-09-07
Pre-Auth Flow Sheet
Pre-Authorization / Concurrent Review Request Form 10-23-07 and 11-06-07
Therapy Referral (undated)
Therapy Referral 11-16-07
Physician Evaluation Notes (unsigned) 10-19-07, 10-30-07, 11-16-07
Official Disability Guideline (ODG) -TWC Treatment Guidelines, Other (cited-not provided)

PATIENT CLINICAL HISTORY:

The medical records presented for review begin with a therapy referral (undated). The October 19, 2007 physician progress notes noted the date of surgery (08-02-07) and that there was "good passive range of motion" of both shoulders. Follow-up was scheduled for one month later.

Follow-up occurred 11 days later noting the complaints of shoulder pain, and now it is reported that there is a restriction in the claimant's motion. The treating physician describes the rotator cuff tear repair, as being difficult and indicated those 4 months of therapy would be necessary to complete the rehabilitation. It was noted that claimant had some weakness in the shoulder, flexion to 140^0 and abduction to 90^0. Plain films noted the acromiohumeral space to have a good decompression and the distal clavicle excision to be generous. An MRI arthrogram of the shoulder was recommended and the claimant is kept off work.

On November 16, 2007, the physician re-evaluated the claimant, notes the same range of motion and feels that continued rehabilitation is needed. MRI was requested.

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

In the opinion of the Reviewer, the requested services were not medically necessary. The Reviewer commented the claimant underwent surgery and based on the progress notes had good response to rehabilitation. The claimant was not noted to be doing any home based exercises. According to the Reviewer the claimant is well past the time of passive rehabilitation. From the records, the claimant has very good range of motion and the modalities requested are passive. {Electrical stimulation, paraffin, ultrasound, massage and manual techniques} In the opinion of the Reviewer, these modalities were indicated in the initial phase but not this many weeks after the date of surgery.

As noted in the ODG, up to 24 visits over 14 weeks are supported. The exact amount of physical therapy already completed is not documented. Further, the modalities requested do not address strengthening or the range of motion as required by the treating physician.

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**
- 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)**