



Notice of Independent Review Decision

DATE OF REVIEW: 4/14/08

IRO CASE #: **NAME:**

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for manual therapy techniques.

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

Texas licensed Orthopedic Surgeon.

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 or not medical necessity exists for each of the health care services in dispute.

The previously denied request for manual therapy techniques.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Cover Letter dated 4/9/08.
- Fax Cover Sheet/Note dated 4/7/08, 4/4/08.

- Notice to CompPartners, Inc. of Case Assignment dated 4/7/08.
- General Information Note (unspecified date).
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 4/4/08.
- Company Request for Independent Review Organization dated
- Request Form Request for a Review by an Independent Review Organization dated 3/25/08.
- Determination Notification Letter dated 3/17/08, 3/7/08.
- Peer Review Report dated 3/17/08, 3/7/08.
- Follow-Up Visit Report dated 3/14/08, 3/7/08, 2/29/08, 11/30/07, 10/12/07, 9/21/07, 9/7/07.
- Re-Evaluation/Re-Examination Report dated 3/4/08.
- Referral Form dated 2/29/08.
- Texas Workers' Compensation Pre-Authorization or Concurrent Review Request (unspecified date).

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Male

Date of Injury:

Mechanism of Injury: Not provided for this review.

Diagnosis:

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

The patient is a male with the date of injury of xx/xx/xx. The mechanism of injury was not provided for review. The diagnoses included status post undefined surgery left shoulder on an undefined date and bursitis of the shoulder. He was also diagnosed with new bursitis of the shoulder by Dr. **Information** from March 7, 2008 indicated the patient had received 54 postoperative physical therapy sessions and 20 work conditioning sessions to that date. **The March 17, 2008, information indicated review of the clinic notes from Dr. for November 30, 2007 and February 29, 2008 of which the notes were not provided for review,** revealed the patient with a well maintained range of motion of left shoulder, with pain on range of motion and crepitus was present. The MRI of the shoulder performed on an unknown date was negative. **The note on that date that request 12 patient PT sessions would not being medically necessary for bursitis but noted the normal treatment is steroid injection into the subacromial space, which had not been performed.** The rationale for the adverse determination of the requested manual therapy techniques is the medical information provided for review did not contain sufficient information that would support the need for manual therapy techniques. At this time, the current diagnosis of bursitis of the shoulder would better be treated by other means. The Official Disability Guidelines do not note manual therapy as a recommended treatment for bursitis.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines, Treatment Index, 6th Edition (web), 2008, Shoulder—Physical therapy, Manipulation.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).