

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/05/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work conditioning program times twenty sessions (97545, 97546).

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

D.C., Diplomate of Congress of Chiropractic Consultants, 22 years of active clinical chiropractic practice, Texas Department of Insurance Division of Workers' Compensation Designated Doctor Approved Doctor's list, Impairment Rating and Maximum Medical Improvement Certified through Texas Department of Insurance Division of Workers' Compensation

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
?	97545	NA	<i>Prosp</i>	20		?		?	<i>Upheld</i>
?	97546	NA	<i>Prosp</i>	20		?		?	<i>Upheld</i>

INFORMATION PROVIDED FOR REVIEW:

1. TDI Case Assignment
2. Letters of denial, 01/29/08 and 0/2/05/08 including criteria used in denial, ODG
3. Correspondence from treating doctor, 03/07/07, 07/17/07, 0/19/07, 09/07/07
4. Operative report 06/05/07
5. Functional Capacity Evaluation, 12/11/07
6. Functional Capacity Evaluation, 01/22/08

SUMMARY OF INJURED EMPLOYEE CLINICAL HISTORY:

The records indicate the injured worker is a male who injured his right shoulder and left elbow while assembling some heating units. He was placing screws in the core. He was pushing and applying great pressure with his arms and shoulders and developed pain in the right shoulder and left elbow.

The injured worker was initially treated by the company doctor. He had about six visits of physical therapy and returned to work. On 03/07/07 he changed treating doctors, and additional treatment was given. Review of the records indicates the patient had a diagnosis of right shoulder impingement syndrome, ulnar nerve neuritis, left elbow, olecranon bursitis, left elbow, right shoulder, upper extremity, left elbow, and forearm pain, spasms, and weakness. On 06/05/07 the patient underwent arthroscopic surgery to repair the rotator cuff. The patient had received approximately 33 sessions of postoperative rehabilitation in the form of physical therapy and had progressed and received ten sessions of work conditioning. In addition, he received a Functional Capacity Evaluation. The most recent one was on 01/22/08, which revealed the patient had responded to the treatment he received and had improved in all areas tested.

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

At this point in time, it has been well over a year since the patient's initial injury and nine months since his surgical intervention. He has received a sufficient amount of postoperative rehabilitation and a work conditioning program. There is not sufficient documentation to clinically justify the need for additional work conditioning program. The patient has responded well to the treatment he has received, and at this point, he should be able to return to work and continue to utilize a self-directed home exercise program.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with 22 years of practice established, accepted chiropractic and 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 national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)