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Notice of Independent Review Decision

DATE OF REVIEW: 11/02/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational therapy three times a week for four weeks to include CPT codes 97110, 97530, and 97035

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

Board Certified in Orthopedic Surgery

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.

Occupational therapy three times a week for four weeks to include CPT codes 97110, 97530, and 97035 - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 04/07/08, 05/05/08, 05/20/08, 06/17/08, 07/22/08, 10/07/08, 10/21/08, 11/18/08, 12/16/08, 01/13/09, 02/10/09, 03/11/09, 04/17/09, 05/29/09, 07/09/09, 07/28/09, and 09/11/09

DWC-73 forms filed by Dr. dated 06/17/08, 07/22/08, 10/07/08, 10/21/08, 11/18/08, 12/16/08, 01/13/09, 02/10/09, 04/17/09, 05/29/09, 07/28/09, and 09/11/09

An MRI of the right shoulder interpreted by M.D. dated 06/25/08

A note from Dr. dated 08/26/08

A chest x-ray interpreted by M.D. dated 09/24/08

An operative report from Dr. dated 09/24/08

Evaluations from O.T.R., C.H.T. dated 11/05/08, 12/04/08, 01/05/09, 02/09/09, 03/05/09, 04/24/09, and 08/04/09

Physical therapy with Ms. dated 11/20/08, 11/24/08, 11/26/08, 11/28/08, 12/03/08, 12/04/08, 12/05/08, 12/09/08, 12/10/08, 12/12/08, 12/15/08, 12/18/08, 12/22/08, 12/24/08, 12/31/08, 01/05/09, 01/07/09, 01/09/09, 01/12/09, 01/14/09, 01/19/09, 01/21/09, 01/26/09, 01/28/09, 01/30/09, 02/02/09, 02/04/09, 02/06/09, 02/09/09, 02/11/09, 02/13/09, 02/17/09, 02/19/09, 02/24/09, 02/26/09, 02/27/09, 03/03/09, 03/05/09, and 04/24/09

A Designated Doctor Evaluation with M.D. dated 03/17/09

A DWC-73 form from Dr. dated 03/17/09

A Functional Capacity Evaluation (FCE) with D.C. dated 03/27/09

A letter of non-certification, according to the Official Disability Guidelines (ODG), from M.D. dated 08/10/09

A letter of non-certification, according to the ODG, from M.D. dated 09/03/09

A letter from Dr. dated 09/18/09

A Carrier Submission form from the Law Offices dated 10/15/09

The ODG Guidelines were provided by the carrier

PATIENT CLINICAL HISTORY

On 04/07/08, Dr. performed a steroid injection into the right subacromial space. An MRI of the right shoulder on 06/25/08 showed a small tear of the distal anterior aspect of the supraspinatus tendon and a partial tear of the anterior aspect of the tendon, as well as a small partial tear of the anterior margin of the infraspinatus tendon and mild AC joint degenerative changes. Right shoulder surgery was performed by Dr. on 09/24/08. Physical therapy was performed with Ms. from 11/20/08 through 04/24/09 for a total of 39 sessions. On 03/17/09, Dr. felt the patient was not at Maximum Medical Improvement (MMI) and recommended right shoulder surgery. An FCE with Dr. on 03/27/09 indicated the patient functioned at the sedentary-light to light physical demand level. On 04/24/09, Ms. recommended further therapy three times a week for four to six weeks. On 07/28/09, Dr. performed a steroid injection into the glenohumeral joint. On 08/04/09, Ms. recommended further therapy three times a week for four to eight weeks. On 08/10/09, Dr. wrote a letter of non-authorization for 12 sessions of occupational therapy. On 09/03/09,

Dr. also wrote a letter of non-authorization for the therapy. On 09/11/09, Dr. placed the patient at MMI with a 4% whole person impairment rating.

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

The patient was injured on xx/xx/xx and a right rotator cuff repair was performed on 09/24/08. The patient is now over xxx year status post surgical procedure. The ODG allows for 24 visits of therapy over 14 weeks following a rotator cuff repair. The patient did receive this amount of therapy visits and in fact, exceeded that. During the patient's original therapy, she should have been instructed in an active home therapy program and that would be more than sufficient at this time. Therefore, the requested occupational therapy three times a week for four weeks for the right shoulder to include CPT codes 97110, 97530, and 97035 would neither be reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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
- 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)**