

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 11/24/2010
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Appeal for WH x 10 days (97545, 97546)

QUALIFICATIONS OF THE REVIEWER:

Physical Med & Rehab, Pain Management

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)

Appeal for WH x 10 days (97545, 97546) Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Fax page dated 11/11/2010
2. Notice of assignment dated 11/9/2010
3. Notice of assignment dated 11/9/2010
4. Request form dated 11/8/2010
5. Letter MD dated 10/28/2010
6. Letter of medical necessity I OTR dated 10/22/2010
7. Form DO dated 10/20/2010
8. Preauthorization determination by author unknown dated 10/19/2010 & 11/1/2010
9. Physical performance evaluation by author unknown dated 10/18/2010
10. Functional abilities by author unknown, dated 10/14/2010
11. Physical performance evaluation by author unknown dated 10/14/2010
12. Preauthorization request dated 10/12/2010 & 10/22/2010
13. Re-evaluation OTR dated 10/8/2010
14. Progress note PhD dated 10/8/2010
15. Work simulative section by author unknown, dated 8/16/2010
16. section by author unknown, dated 8/16/2010
17. Initial rehabilitation evaluation by author unknown, dated 8/16/2010
18. Functional abilities evaluation by author unknown, dated 6/28/2010 & 8/4/2010
19. Physical performance test by author unknown, dated 5/25/2010
20. History note MD, dated 5/17/2010
21. Patient information by author unknown, dated 4/28/2010 & 5/25/2010

Name: Patient_Name

22. History form by, dated 4/21/2010 to 10/20/2010
23. Operative report by MD, dated 4/8/2010
24. Prescription note by author unknown, dated 4/5/2010
25. Health insurance claim form by author unknown, dated 3/29/2010
26. Letter by MD, dated 3/25/2010
27. Work status report by author unknown, dated 3/25/2010
28. Health insurance claim form by MD, dated 1/29/2010
29. Designated doctor evaluation MD, dated 1/19/2010
30. Corrected report by MD, dated 10/5/2009
31. Letter by MD, dated 10/1/2009
32. Initial medical examination by MD, dated 9/3/2009
33. Plans / goals by, dated unknown
34. Letter by author unknown, dated unknown
35. Hand grip strength dated unknown

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

This is a injured employee who was injured xx/xx xx while working for xxxx. He suffered left shoulder injury, eventually undergoing left open rotator cuff repair. He has subsequently undergone 30 ODG recommended postoperative physical therapy (PT) visits for his diagnosis with progression of physical function and improvement. The records demonstrate continued physical and psychological dysfunction relative to job demand level which is medium to heavy in nature. The injured employee then participated in 10 visits of work hardening with objective improvements noted on the 10/14/10 functional capacity evaluation (FCE). It is clearly noted that the injured employee is not capable of completing job duties without restrictions. His occupation requires 75 pounds of lifting on occasion and 35 pounds frequently. He is currently limited to 55 pounds of occasional lifting, no more than 2 hours per day. Shoulder ranges of motion are documented as improved 8/15/10 to 10/8/10 interval with increased shoulder flexion, extension, abduction, internal and external rotation.

The FCE on 10/15/10 indicated the injured employee can lift up to 120-130 pounds with grip strength of approximately 100 pounds. Depression and anxiety scores are essentially normal. Occupation is medium-heavy physical demand levels (PDL).

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

Based on the submitted medical records and the official disability guideline recommendations the request for additional work hardening sessions is medically necessary and the recommendation is to overturn the previous denial. This is a injured employee who was injured xx/xx/xx while working for xxxx. He suffered left shoulder injury, eventually undergoing left open rotator cuff repair on 4/8/10. He has subsequently undergone 30 ODG recommended postoperative physical therapy (PT) visits for his diagnosis with progression of physical function and improvement. The records demonstrate continued physical and psychological dysfunction relative to job demand level which is medium to heavy in nature. The injured employee then participated in 10 visits of work hardening with objective improvements noted on the 10/14/10 functional capacity evaluation (FCE). It is clearly noted that the injured employee is not capable of completing job duties without restrictions. His occupation requires 75 pounds of lifting on occasion and 35 pounds frequently. He is currently limited to 55 pounds of occasional lifting, no more than 2 hours per day. Shoulder ranges of motion are documented as improved 8/15/10 to 10/8/10 interval with increased shoulder flexion, extension, abduction, internal and external rotation. Given the injured employee's progress with initial trial treatment to date but continued functional deficient the final work hardening sessions should be considered medically necessary per the guidelines. The recommendation is to overturn the previous denial.

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

Name: Patient_Name

- 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)