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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jan/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
URGENT Home Health Care 7xWk x 3Wks x 4hrs x day

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Dr. office notes 09/23/09, 10/05/09, 10/09/09
MRI right shoulder 09/30/09
Dr. prescription 11/02/09, 11/19/09
Peer review Dr. 11/05/09
Peer review Dr. 11/09/09
Physical therapy evaluation 11/23/09
Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Shoulder., health services

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female who underwent a right shoulder arthroscopy, Neer acromioplasty and Mumford procedure on 11/11/09. The physician ordered home health services post op daily for three weeks. The health services were denied on peer review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
supports health services for medical treatment for patients who are homebound. Medical treatment does not include homemaker services or personal care. Based on the information provided, the claimant would not meet the ODG criteria for home health services. There is no indication that she was homebound or that the services were requested for medical treatment. The medical records provided do not support the necessity for home health

services. The reviewer finds that medical necessity does not exist for URGENT Health Care 7xWk x 3Wks x 4hrs x day.

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 Updates. Shoulder.

health service

Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or "intermittent" basis. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. (CMS, 2004)

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

[ ] ACOEM-AMERICA 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

[X] 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)