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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

May/16/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational Therapy 3xWk x 4 Wks 97010 97140 97110 Left Shoulder

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

MD, Board certified in Physical Medicine and Rehabilitation with expertise in 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines
Adverse Determination Letters, 3/31/10, 4/16/10
Surgery Group 3/10/10, 3/15/10, 3/25/10

PATIENT CLINICAL HISTORY SUMMARY

This patient has a date of birth of x/x/xxxx. The patient reported an injury x/x/xxxx. He is left-handed. His complaints are left shoulder and neck pain. He did have a left shoulder arthroscopy and labral debridement 12/2009. He has had 24 PT visits. He has neck pain of 3/10. The therapy notes do not document continued objective improvement or goals for continued treatment.

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

The ODG guidelines do recommend therapy in shoulder pain. This patient has had arthroscopic treatment. ODG recommends 24 visits of PT following this surgery. The records indicate the patient has had 24 PT sessions. ODG indicates that there should be fading treatment frequency and introduction and discharge to a home exercise program. The notes provided do not document continued improvement with therapy or the need for continued supervision of the exercise program. The request for additional therapy does not

satisfy the ODG. The reviewer finds that medical necessity does not exist for Occupational Therapy 3xWk x 4 Wks 97010 97140 97110 Left Shoulder.

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
- 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)