

SENT VIA EMAIL OR FAX ON
Mar/29/2011

IRO Express Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Mar/24/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 3 X 4 Right Shoulder/Right Hand

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

Board Certified 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

1. Cover sheet and working documents
2. Fax cover sheet dated 02/28/11
3. Order requisition dated 12/10/10
4. Office visit note dated 12/10/10, 12/21/10
5. Utilization review determination dated 03/07/11, 01/10/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. The patient reported injury on this date secondary to repetitive use. The earliest submitted record is an office visit note dated 12/10/10. The patient is noted to be status post right carpal tunnel release on 06/16/10. The patient has been followed for right shoulder rotator cuff tendonitis as well. The patient has reportedly been seen by a designated doctor who recommended therapy to the shoulder; however, this has not been done, and the patient has had no therapy for the hand. The patient underwent injection of dexamethazone and lidocaine on this date.

Hand/upper extremity evaluation dated 12/21/10 notes that right shoulder range of motion is flexion 75, extension 15, abduction 40, IR 25 and ER 0. Hawkins and Neer's testing is positive. The patient has been authorized for hand therapy.

Initial request for physical therapy was non-certified on 01/10/11 noting that the patient is 6 months out from surgery and 18 months out from date of injury. It is unclear how monitored therapy would be helpful this far removed from the surgery or injury. A shorter course of therapy might be reasonable to establish a home exercise program. The denial was upheld on appeal on 03/07/11 noting that guidelines allow up to 10 visits after an injury or diagnosis of impingement syndrome. The request exceeds guidelines. The amount of prior therapy to the shoulder is unclear. Patients typically would have received some type of conservative care or therapy well before now given the patient's date of injury. It is not entirely clear that the patient's symptoms at this time are due to an injury over one and a half years ago.

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

Based on the clinical information provided, the request for PT 3 x 4 right shoulder/right hand is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained injuries in xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient underwent right carpal tunnel release on 06/16/10 and the submitted records indicate that in December 2010 a request for physical therapy was authorized. It is unclear if the patient has undergone any physical therapy for the hand or shoulder at this point, and if so, the patient's objective, functional response to therapy is not documented. Given the patient's date of injury, it is unclear why physical therapy is being requested at this time. As pointed out by the previous reviewer, patients typically would have received some type of conservative care or therapy well before now. The request exceeds the Official Disability Guidelines, and there are no exceptional factors of delayed recovery provided to support exceeding guidelines. Given the current clinical data, the request is not indicated as medically necessary, and the two previous denials are upheld.

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)