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Notice of Independent Review Decision

DATE OF REVIEW: 2/17/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of work conditioning 5 x/week for 2 weeks multiple sites (6 hrs/day). (97545 and 97546)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of work conditioning 5 x/week for 2 weeks multiple sites (6 hrs/day). (97545 and 97546)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Clinic and Provider.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Clinic: 11/30/10 FCE report.

Provider: 12/9/10 preauth request letter, 12/8/10 WC script, 6/7/10 to 12/8/10 status reports, 11/5/10 preauth request), surgery scheduling form (blank), 11/3/10 office report, 1/5/11 request for appeal letter, 12/15/10 denial letter, 6/25/10 brain MRI report, 6/23/10 right shoulder MRI report, 6/8/10 cervical spine CT scan report and 6/8/10 brain CT scan report.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured when he fell from a ladder. He was seen by Dr. who diagnosed right shoulder sprain/strain, left lumbar sprain/strain, open wound to the face, closed fracture of the nasal bones, and post concussion syndrome. Treatment recommendations included physical therapy, analgesics, naproxen, sedentary work only, MRI if no improvement of the right shoulder in one week, and referral for the [nasal] fracture. Some of the document is unreadable because the copy is blurred. On the follow-up visit a Neurology referral was made.

In 6/2010, neurology evaluation by was in progress. Dr. requested MRI of the shoulder and recommended starting physical therapy for range of motion. In 6/2010 Dr. requested referral for orthopedic evaluation of the injured shoulder. In 7/2010 Dr. noted that that the orthopedist planned arthroscopy of the shoulder and was awaiting pre-surgical clearance from the injured worker's primary care physician.

Apparently the injured worker underwent arthroscopic repair of the right shoulder in August 2010, but records of the actual procedure were not submitted for this review. The narrative of the FCE dated November 2010 states that the injured worker had undergone surgery to the right shoulder in August 2010, followed by 12 sessions of physical therapy. In a utilization review report the surgery was described as right shoulder subacromial decompression and rotator cuff repair in August 2010, followed by 12 sessions of physical therapy.

The injured worker was seen for plastic surgery consultation regarding the nasal fracture. He advised that septorhinoplasty would be needed to correct the problem. A request was submitted for CPT 30420, diagnosis 802.0: Closed Fracture of Nasal Bone.

According to Dr. note the [plastic] surgery had been performed on the preceding Friday. Further physical therapy [for the shoulder] had been denied. Dr. noted that the injured worker had been seen by Dr. on 11/23/2010 and had a follow-up appointment on 12/22/2010. Dr. recommended referral for functional capacity evaluation, for return to full duty. The injured worker remained on work restrictions.

The FCE was performed. The injured worker performed at a medium PDL, with some restriction of lumbar range of motion and right shoulder range of motion. Dr. reviewed the FCE results. He submitted a request for Work Conditioning.

Request for precertification of the work conditioning program was submitted. Notification of adverse determination was given 12/15/2010. Request for an appeal was submitted. The requested procedures were non-authorized on reconsideration. A request for a review by an Independent Review Organization was submitted 01/21/2011.

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

The injured worker had 12 sessions of physical therapy after undergoing right shoulder subacromial decompression and rotator cuff repair in August 2010. Further therapy was non-authorized. The reason for the denial of further therapy was not mentioned in Dr. records but the request for an appeal states that additional physical therapy had been denied due to the lack of additional progress.

Impaired right shoulder range of motion was subsequently documented on the FCE. After reviewing the FCE results Dr. requested Work Conditioning. The proposed Work Conditioning program is specifically defined as an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. The goals of the therapy program are reasonable.

In the ODG Treatment Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic) (updated 02/11/11) pertaining to Rotator cuff syndrome/Impingement syndrome:

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

- According to the ODG Treatment Integrated Treatment/Disability Duration Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 02/09/11). Pertaining to work conditioning:

Single-Discipline Exercise Approaches: Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of non-operative therapy between acute PT and

interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT

WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work. Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

The reviewer indicates that the patient has met the applicable ODG requirements for participation in the requested program. Therefore, the program is medically necessary at this time.

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**
- ☒ **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)**