

Notice of Independent Review Decision

PEER REVIEWER FINAL REPORT

DATE OF REVIEW: 3/7/2011
IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient occupational therapy (OT) two (2) times a week for six (6) consisting of one (1) unit of paraffin bath, 1 unit of electrical stimulation, 2 unites of therapeutic exercise, 2 units of neuromuscular re-education, 2 units of manual therapy and 2 units of therapeutic activities of the lumbar spine, left shoulder and left elbow

QUALIFICATIONS OF THE REVIEWER:

Occupational Medicine
MD

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

Outpatient occupational therapy (OT) two (2) times a week for six (6) consisting of one (1) unit of paraffin bath, 1 unit of electrical stimulation, 2 unites of therapeutic exercise, 2 units of neuromuscular re-education, 2 units of manual therapy and 2 units of therapeutic activities of the lumbar spine, left shoulder and left elbow Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The injured employee is a male whose industrial injury is listed as xx/xx/xxxx. On that day while down the stairs he slipped and fell down the entire stairs injuring his neck, back, and both shoulders. He is status post cervical fusion ACDF (anterior cervical discectomy and fusion) (2004), left RC (rotator cuff) repair (2005 and 2006), 2 left shoulder arthroscopies (2008), right RC repair (11/9/05), and 2 right shoulder arthroscopies (2008 and 2009). His additional post injury care include ESI x 3 to C-spine, Lumbar spine x3, and bilateral injections to shoulders x 3, L cubital tunnel release (2010). He has been treating with a Dr. who diagnosed him with the followings:

- . Rotator Cuff Syndrome NOS
- . Postsurgical Region Dis NEC
- . Postsurgical States NEC
- . Other Joint Derangement
- . Joint Dis NOS-Shoulder
- . Joint Pain-Hand

The request is for outpatient occupational therapy (OT) two (2) times a week for six (6) consisting of one (1) unit of paraffin bath, 1 unit of electrical stimulation (e-stim), 2 units of therapeutic exercise, 2 units of neuromuscular re-education, 2 units of manual therapy and 2 units of therapeutic activities as related to the lumbar spine, left shoulder and left elbow.

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

This injured employee has recently received extensive PT/OT including 20 sessions in 2010 and 12 sessions in 2009. On his latest PT evaluation he showed decreased ROM (range of motion) and decreased strength during the muscle testing (grip/pinch). It appears that this injured employee's response to PT/OT has plateaued and reached a steady state. After numerous sessions of PT/OT for the last x years (post injury) a request for additional treatment is not reasonable or medically necessary. It is not likely that more sessions of OT/PT will result in Functional Improvement which can be exemplified as restoration of flexibility, strength, endurance, function, range of motion, and reduction of pain and discomfort. The above request exceeds the ODG established guidelines and is recommended for non-certification. The recommendation is to uphold 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
- 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)