

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 09/26/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

PT 3x4 Right Shoulder 97010 97140 97035 97530 97116 97113

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

The TMF physician reviewer is board certified in orthopedic surgery with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

It is determined that the PT 3x4 Right Shoulder 97010 97140 97035 97530 97116 97113 is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a work related injury on xx/xx/xx when the vehicle he was driving overturned. This resulted in a right shoulder dislocation and brachial plexus traction injury. He underwent arthroscopic rotator cuff repair, subacromial decompression and glenoid labrum debridement on 05/17/2011. An EMG/NG study done on 04/14/11 confirmed a brachial plexus traction injury producing complaints of numbness in the right upper extremity. The patient has

been provided with 19 sessions of physical therapy in the post operative period after the arthroscopic surgical procedure of 05/17/11. The current request is for 12 additional physical therapy sessions. The patient has a restored functional range of motion. His symptoms of right upper extremity pain and numbness are improving.

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

This request exceeds the ODG Physical Therapy Guidelines. The patient has a restored functional range of motion and has been trained in a home exercise program. The medical necessity for additional supervised physical therapy has not been established.

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)