



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

December 27, 2011

DATE OF REVIEW: 12/27/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Is the 4 weeks/12 visits of physical therapy sessions for the left shoulder deemed medically necessary for the patient?

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

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. 12/14/2011,
2. Notice of assignment to URA 12/14/2011,
3. Confirmation of Receipt of a Request for a Review by an IRO 12/14/2011,
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 12/14/2011
6. Appeal 12/09/2011, procedure note 12/09/2011, insurance information 12/09/2011, 12/07/2011, pre-authorization 12/06/2011, Insurance Information 12/06/2011, pre-authorization request form 12/01/2011, progress note 11/30/2011, procedure note 11/28/2011, 11/23/2011, 11/21/2011, 11/18/2011, 11/16/2011, 11/14/2011, 11/11/2011, 11/09/2011, 11/07/2011, 11/04/2011, insurance information 11/03/2011, progress note 10/26/2011, flow sheet 08/03/2011, operative report 08/03/2011.
7. ODG guidelines were not provided by the URA

PATIENT CLINICAL HISTORY:



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



The patient is a male who was treated by therapy with regard to a left shoulder injury. The patient has been noted to have been considered for 12 sessions of physical therapy. The patient was injured on xx/xx/xx, and had already reportedly completed 24 visits of postoperative therapy to the left shoulder.

The most recent records were physical therapy notes from Irving Orthopedic and Sports Medicine physical therapy, in which it was noted on December 9, 2011, that the patient "tolerated treatment well." The patient was noted to be considered for reevaluation on December 19 with regard to the possibility of further therapy.

The records from the physical therapy notes as of November 30, 2011, reveal that the patient had undergone a left shoulder arthroscopic rotator cuff repair as of August 3, 2011. The patient, in particular, also underwent acromioplasty, distal clavicle excision, synovectomy, biceps tenotomy, and pain pump catheter placement. As of November 30, 2011, there were 150 degrees of flexion, improved from 110 degrees, and abduction of 115 degrees, improved from 95 degrees. External rotation was 60 degrees, and internal rotation was 70 degrees. Muscle testing was 4-/5 globally. The additional submitted records included the notes from Orthopedics and Sports Medicine, which were reviewed in detail, documenting the overall subjective and objective findings per the therapist in particular. The operative summary was dated August 3, 2011, from Hospital, at which the patient underwent the aforementioned procedures.

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

The applicable Official Disability Guidelines support up to approximately 24 visits of therapy postoperative arthroscopic surgery. In this case, there are no extenuating circumstances and no valid rationale that would support other than a prescribed self-administered therapy program to potentially further consolidate gains already documented to have been achieved. There is no valid rationale submitted with evidence as to why any remaining rehabilitation could not be rendered within such a prescribed therapy context. The patient has clearly achieved quite reasonable motion and strength overall that would exclusively at this time support a prescribed home self-administered, independent program, therefore the request of physical therapy sessions, 4wks/12 visits of the left shoulder, are not deemed medically necessary and the request remains upheld.



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



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)

REFERENCES:

1. Official Disability Guidelines, physical therapy section of the shoulder chapter.