

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 03/11/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy right shoulder (12 visits)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

| <i>Primary Diagnosis Code</i> | <i>Service Being Denied</i> | <i>Billing Modifier</i> | <i>Type of Review</i> | <i>Units</i> | <i>Date(s) of Service</i> | <i>Amount Billed</i> | <i>Date of Injury</i> | <i>DWC Claim #</i> | <i>Upheld Overturn</i> |
|-------------------------------|-----------------------------|-------------------------|-----------------------|--------------|---------------------------|----------------------|-----------------------|--------------------|------------------------|
| | | | <i>Prosp.</i> | | | | | | <i>Upheld</i> |

INFORMATION PROVIDED FOR REVIEW:

1. TDI case assignment.
2. Certificate of Independence of the Reviewer
3. Letters of denial 12/12 & 12/8/11, including the criteria used in the denial
4. Treating doctor's evaluation and follow up exams, 8/22/11 through 2/15/12
5. Physical therapy assessments, referrals & plan of care 9/6/11 through 12/12/11

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

The patient underwent open rotator cuff repair and biceps tenodesis and has attended 34 post

op PT visits following a work-related injury on xx/xx/xx. The patient has good passive ROM and more PT has been requested due to continued weakness.

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

The basis for the requested procedures appears to be ongoing weakness. The PT notes demonstrate excellent passive ROM and there is insufficient medical documentation as to why continued strengthening could not be adequately performed at home with a home program and resistance band workout. The request exceeds the ODG guidelines and is not medically reasonable or necessary.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, 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 national accepted medical literature: OKU Hand / Wrist.
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)