Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/08/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
additional 12 sessions to supervised rehab

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon (Joint)

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds medical necessity is not established for an additional 12 sessions to supervised rehab.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Physical therapy SOAP notes 02/28/12-07/30/12
Emergency room evaluation 02/19/12
Employer's first report of injury or illness xx/xx/xx
Radiographs shoulder pelvis cervical spine lumbar spine thoracic spine 02/19/12
Operative report 05/21/12
MRI left shoulder 04/16/12
Clinical notes Dr. 02/23/12-03/08/12
Clinical notes Surgeon Associates 03/20/12-08/14/12
Prior reviews 08/01/12 and 08/17/12

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who sustained an injury on xx/xx/xx when he fell. The patient has had prior history of left rotator cuff repairs and MRI studies from 04/12 identified a recurrent full thickness rotator cuff tear in the left shoulder. The patient underwent diagnostic arthroscopy to include subacromial decompression release of the coracoacromial ligaments on 05/21/12. The patient was seen for extensive physical therapy from 05/12 through 07/30/12. The physical therapy progress report dated 07/30/12 identified persistent pain with range of motion of the left shoulder and limited range of motion. No specific measurements from this evaluation were provided for review. Clinical evaluation on 08/14/12 addressed the lumbar spine. The patient was recommended for a functional capacity evaluation and work conditioning. The request for continued post-operative physical therapy for the left shoulder three times a week for four weeks was denied by utilization review on 08/01/12 as there was no evidence of significant progress with physical therapy and range of motion and strength were unchanged in the left shoulder. The request was again denied by utilization review on

08/17/12 due to regression with supervised rehabilitation.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Based on the clinical documentation provided for review, the patient has persistent weakness and loss of range of motion to left shoulder despite extensive physical therapy after the surgical intervention in May of 2012. The most recent clinical evaluation from 08/14/12 focused on the lumbar spine and there was no additional evaluation of the left shoulder that would reasonably support continued physical therapy. Based on the physical therapy progress reports the patient regressed with continued physical therapy and current evidence based guidelines do not recommend continuing physical therapy in the absence of progression of functional abilities. As the clinical documentation provided for review does not support continuing physical therapy based on guideline recommendations, the reviewer finds medical necessity is not established for an additional 12 sessions to supervised rehab and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA 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

[X] 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)