

Notice of Independent Review Decision

October 15, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Continued physical therapy: 2 x Wk x 4 Wks Left Shoulder and Left Hip

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician is a member of the Texas Medical Board. The physician has a private practice of Physical Medicine & Rehabilitation. The physician has published in medical journals. The physician is a member of his state and national medical societies.

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 medical necessity exists for each of the health care services in dispute.

Upon independent review, the physician finds that the previous adverse determination should be Upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Records Received: 14 page fax 09/25/13 Department of Insurance IRO request, 19 pages of documents received via fax on 09/26/13 URA response to disputed services including administrative and medical. 3 emails with a total of 30 pages attached received 10/03/13 Patient documents response to disputed services including administrative and medical. Dates of documents range from xx/xx/xx (DOI) to 09/25/13.

The DYLL REVIEW

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25 Highland Park Village #100-177 Dallas TX 75205

Phone: 888-950-4333 Fax: 888-9504-4443

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is indicated to be a female who slipped and fell on a wet spot. She received treatment. Following the orthopedic evaluation, she underwent MRI studies involving the left shoulder and left hip. There was no evidence of fracture but some mild osteoarthritis.

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

The patient has undergone orthopedic evaluation as well as eight physical therapy treatment sessions, which is within the guide from the ODG for sprain/strain of hip and shoulder. There is no indication the patient should not be on an active home exercise program to continue rehabilitation.

CRITERIA:

ODG Physical Medicine Guidelines – Shoulder

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Medical treatment, partial tear: 20 visits over 10 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

ODG Physical Medicine Guidelines – Hip

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less).

Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Sprains and strains of hip and thigh (ICD9 843):

9 visits over 8 weeks

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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)