

## Notice of Independent Review Decision

**DATE OF REVIEW: 12/27/12**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Work Conditioning 5x Wk x 2Wks RT Shoulder 97545, 97546

### **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 physical medicine and rehabilitation 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 Work Conditioning 5x Wk x 2Wks RT Shoulder 97545, 97546 was not medically necessary to treat this patient's condition.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 12/10/12
- Decision Letter – 11/02/12, 11/30/12
- Report of Post Arthrogram MRI of the right shoulder – 09/12/12
- Family Medicine Office/Clinic Notes – 08/28/12 to 12/04/12
- Physical Therapy Initial Evaluation – 08/24/12
- Physical Therapy Progress Notes - 09/19/12 to 10/18/12

- Copy of ODG – TWC Integrated Treatment/Disability Duration Guidelines, Shoulder (Acute & Chronic) – 11/29/12

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This injured worker sustained a work related injury on xx/xx/xx when someone pulled on her right shoulder. This resulted in pain to the right shoulder and swelling of the right hand. The patient has been treated with physical therapy but she still complains of right shoulder pain, swelling and limited range of motion. There are also complaints of worsening lateral and posterior neck pain and there is a request for the patient to undergo Work Conditioning 5x Wk x 2Wks RT Shoulder 97545, 97546.

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

The ODG requires documentation of loss of physical capacity and function. This has been improving. The request was for 5 times a week over 2 weeks, which exceeds the intensity advised in the ODG. Further, modified work is encouraged. The MD Guidelines is also approved by DWC for determination of treatment options. It discusses therapies and outcomes for slow recovery. It does not state that work hardening or work conditioning are necessary beyond physical therapy.

**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 KNOWLEDGBASE
- 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)