

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 06/29/13

IRO CASE #:

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

M.D., licensed in the State of Texas, meeting the requirements for Peer Review in the State of Texas for this IRI evaluation, board certified in the specialty of Physical Medicine and Rehabilitation, having practiced this medical specialty for greater than 35 years, currently in active practice, and board certified by ABMS medical specialty Physical Medicine and Rehabilitation

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening (10 units), work hardening add on (total 140 units), physician/team conference.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld** (Agree)
- Overtured** (Disagree)
- Partially Overtured** (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>Amt Billed</i> | <i>Date of Injury</i> | <i>DWC Claim #</i> | <i>Upheld Overturn</i> |
|-------------------------------|-----------------------------|-------------------------|-----------------------|--------------|---------------------------|-------------------|-----------------------|--------------------|------------------------|
| 847.0 | 97546 | | Prosp | 80 | 04/23/13 – 04/30/13 | | Xx/xx/xx | | Upheld |
| 847.0 | 99362 | | Prosp | 2 | 05/09/13 – 05/16/13 | | Xx/xx/xx | | Upheld |
| 847.0 | 97546 | | Prosp | 60 | 05/09/13 – 05/16/13 | | Xx/xx/xx | | Upheld |
| 847.0 | 97454 | | Prosp | 10 | 05/09/13 – 05/16/13 | | Xx/xx/xx | | Upheld |

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

1. TDI case assignment.
2. Letters of denial 04/30/13 and 05/16/13, including the criteria used in the denial.
3. Work hardening pre-authorization request 04/23/13 and request for reconsideration 05/09/13,
4. Request for work hardening program continuation 04/11/13.
5. Treating doctor's follow up note 03/30/13, and radiology report 04/09/13 (MRI left shoulder).
6. Medical case reviews 05/15/13 and 03/04/13.
7. FCE 02/26/13.
8. FCE 03/15/13.

PATIENT CLINICAL HISTORY (SUMMARY):

Information provided for the review indicates that this individual who was involved in a motor vehicle accident underwent initial treatment and evaluation and participation in work hardening. The patient is indicated in Functional Capacity Evaluation to have reached his target level for return to work. The current request is for additional work hardening after the patient has reached his treatment goals or endpoint.

This man is indicated to have been in a motor vehicle accident involving the neck and bilateral shoulders on 09/08/12. The FCE dated 02/26/13 reported the patient had recently completed twelve sessions of rehabilitation and noted on that date he tested at a medium physical demand level. His full-time, full-duty occupation physical demand level was heavy. He was noted to have completed ten sessions of work hardening, and on 03/15/13 he tested at a heavy physical demand level at his full-time, full-duty occupational physical demand level. He continued to have moderate pain and weakness during abduction of the left arm and 90 to 140-degree range with applied resistance and stated patient was capable of returning to work with restrictions.

MRI scan of the left shoulder performed on 04/09/13 reported minimal articular surface fraying involving the distal supraspinatus and infraspinatus tendons with mild to moderate distal tendinosis and no findings of high-grade partial or full thickness tears. It was felt that he had had opportunity to participate in full post injury treatment and had successfully completed the treatments.

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

This man has been afforded all reasonable medical care required by his injury and meets return to work criteria. This would be consistent with ODG criteria.

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 judgment, clinical experience and expertise in accordance with accepted medical Standards
 - Mercy Center Consensus Conference Guidelines
 - Milliman Care Guidelines
 - ODG-Office 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)
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