

DATE: 09/24/14

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 09.24.14

IRO CASE #:

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

M.D., Board Certified in Orthopedic Surgery

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational therapy two times per week for four weeks to the left shoulder

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>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overtured</i>
840.4	97003		Prosp.				Xx/xx/xx		Overtured
840.4	97140		Prosp.				Xx/xx/xx		Overtured
840.4	97010		Prosp.				Xx/xx/xx		Overtured
840.4	97530		Prosp.				Xx/xx/xx		Overtured
840.4	97110		Prosp.				Xx/xx/xx		Overtured

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant underwent surgery on the left shoulder on 09/17/13 for a work-related injury. The original date of injury was xx/xx/xx. The claimant felt a pop in his shoulder. An MRI scan showed a subscapularis tear and a biceps tendon tear. The insurance company denied the request for physical therapy twice. Eight additional visits have been requested; however, the denials from the insurance companies both state there were requests for twelve visits that were denied. Documentation from Physical Therapy report minimal gains with the previously prescribed physical therapy.

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

Based on the claimant's operative procedure and the poor progress with the eighteen postoperative physical therapy visits, a request for six more visits is medically reasonable and necessary based on the Official Disability Guidelines. If this claimant continues to have problems after these six visits, a Functional Capacity Evaluation or a formal reevaluation with the treating orthopedic surgeon would be warranted prior to considering any further therapeutic management.

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)