

MEDICAL REVIEW OF TEXAS

[IRO #5259]

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DATE OF REVIEW: MARCH 26, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of physical therapy

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

MD, Physician Board Certified in Family Practice

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Records from including denial letters from Drs. (2/8/07) (2/22/07)
- Clinical notes from Dr. (12/1/06, 12/15/06, 12/29/06, 1/12/07, 1/24/07, 2/1/07)
- TDI paperwork
- MRI Arthrogram report dated 1/22/07
- Progress notes from Therapy Associates (2/1/07)
- Job Description

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient experienced a work related shoulder injury. (Although one physical therapy note states 5/23/03.) Patient had treatment that culminated in two shoulder surgeries on the right with post operative physical therapy. Dr. notes patient showed minimal progress on 1/12/07 and an MRI arthrogram was done and was essentially normal. His note on 1/24/07 showed definitive improvement with continued physical therapy. Patient had 40 sessions of post operative physical therapy when further physical therapy was requested. This request was not certified and an appeal upheld that denial.

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

PATIENT HAD A SHOULDER INJURY WITH TWO SURGERIES AND POST OPERATIVE PHYSICAL THERAPY. THE LAST SURGERY WAS IN OCTOBER, 2006 AND HE SUBSEQUENTLY HAD 40 SESSIONS OF PHYSICAL THERAPY. MRI ARTHROGRAM WAS BASICALLY NORMAL. THIS AMOUNT OF POST OPERATIVE PHYSICAL THERAPY IS MORE THAN SUFFICIENT TO TREAT PATIENT AND SAFELY TRANSITION HIM TO A HOME EXERCISE PROGRAM. THE RECORDS SHOW NO EXTRAORDINARY CIRCUMSTANCES NOR MEDICAL NECESSITY TO JUSTIFY FURTHER PHYSICAL THERAPY. THEREFORE, THE PRIOR DECISION IS UPHELD.

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

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)**