

RYCO MedReview

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 02/21/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy twice a week for four weeks to include therapeutic exercises (97110)

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

Board Certified in Orthopedic Surgery

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

Evaluations with M.D. dated 11/17/06, 12/11/06, 12/27/06, and 01/21/07
DWC-73 forms from Dr. dated 11/08/06, 12/11/06, and 12/27/06

X-rays of the left shoulder interpreted by M.D. dated 11/08/06
An MRI of the left shoulder interpreted by M.D. dated 11/14/06
Physical therapy evaluations with an unknown therapist (signature was illegible) dated 11/28/06, 12/07/06, and 01/11/07
A letter of authorization from R.N. dated 12/01/06
Physical therapy with the unknown therapist dated 11/28/06, 12/04/06, 12/05/06, 12/07/06, 12/12/06, 12/14/06, 12/15/06, 12/19/06, 12/20/06, 12/28/06, 12/29/06, 01/03/07, 01/05/07, and 01/11/07
Letters of non-authorization from Ms. dated 01/08/07 and 01/11/07
A letter from Business Office Manager dated 01/17/07
A discharge summary from the unknown physical therapist dated 01/29/07
An undated documentation regarding shoulder complaints

PATIENT CLINICAL HISTORY [SUMMARY]:

Dr. recommended a Medrol Dosepak, an MRI, Ultram, Ketoprofen/Lidoderm cream, and light work duty. X-rays of the left shoulder interpreted by Dr. dated revealed probable chronic calcific tendonitis most likely in the rotator cuff. An MRI of the left shoulder interpreted by Dr. on 11/14/06 revealed a type II acromion, degeneration of the inferior labrum, tendinopathy, and subacromial/subdeltoid bursitis. Dr. recommended physical therapy, Flexeril, and continued Ultracet. On 11/28/06, the unknown therapist recommended treatment three times a week for three weeks. Physical therapy was performed with the unknown therapist for a total of 14 sessions. On 12/01/06, Ms. wrote a letter of approval for physical therapy. On 12/07/06, the unknown therapist recommended continued physical therapy. On 12/11/06, Dr. recommended continued physical therapy, topical gel, and Vicodin. On 12/27/06, Dr. recommended continued physical therapy, topical gel, Celebrex, Vicodin, and a trial of Zanaflex. On 01/08/07 and 01/11/07, Ms. wrote letters of non-authorization for further physical therapy. On 01/17/07, Ms. wrote a letter of request for further therapy. On 01/29/07, the unknown therapist discharged the claimant from physical therapy.

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

In my opinion, no. The claimant had a rotator cuff strain. This was months ago. The claimant was treated originally with physical therapy and received twelve physical therapy visits in which they did quite well with. On the latest visit, the claimant had 45 degrees of external rotation and had over 140 degrees of flexion and abduction in the shoulder. She was actually doing very well, therefore it is outside of the ACOEM and ODG Guidelines to continue physical therapy for this. The claimant should have been instructed by this point on a home exercise program. Again, I do not believe further supervised physical therapy is necessary, now being months out from the original injury and having

received twelve therapy visits to this point and doing as well as the claimant is doing.

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)**