



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: July 23, 2007

IRO Case #:

Description of the services in dispute:

Pre-authorization request – physical therapy.

A description of the qualifications for each physician or other health care provider who reviewed the decision

This reviewer is Board certified in Physical Medicine & Rehabilitation (1979). The physician providing this review is a Diplomate, American Academy of Physical Medicine and Rehabilitation; and Diplomate, American Board of Electrodiagnostic Medicine. This reviewer is a member of the American Spinal Injury Association, American Academy of Physical Medicine and Rehabilitation, State Academy of Physical Medicine and Rehabilitation, and State Medical Society. This reviewer has held various academic positions, is currently an Adjunct Associate Professor, and has authored numerous publications. The reviewer has additional training in Acupuncture. This reviewer is licensed to practice in four states and has been in practice since 1978.

Review Outcome

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

Upheld

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.

Medical necessity does not exist for the requested physical therapy.

Information provided to the IRO for review

Records From State:

Letter to Texas Department of Insurance, 7/2/07

Confirmation of receipt of a request for a review by an independent review organization, 6/29/07

Company request for IRO, 7/2/07

Request for a review by an independent review organization, 6/21/07

Non-authorization notice, 5/11/07

Non-authorization after reconsideration notice, 6/1/07
Notice to Medical review Institute of America, INC. of case assignment, 7/3/07

Records From Insurance Company:

Hand delivery form, 7/9/07
Non-authorization notice, 5/11/07
Non-authorization after reconsideration notice, 6/1/07
ODT-TWC integrated treatment/disability duration guidelines, undated
Operative report, 3/8/07
SOAP note, 3/12/07
Progress note, 5/3/07
Handwritten notes, 3/07
Sensory nerve conduction, 5/2/07
Orthopedic note, 4/16/07
Orthopedic note, 5/7/07
Prescription, 5/7/07
Letter, DO, to whom it may concern, 6/16/07
Prescription, 2/19/07
Prescription, 3/8/07
Prescription, 4/9/07
Prescription, 5/7/07
SOAP note, 3/12/07
Handwritten notes, 3/07
Progress note, 5/3/07

Patient clinical history [summary]

The patient is male who was injured after falling with the trauma to the left shoulder. The patient had surgery on the left shoulder on 3/8/07. There was a distal clavicle excision, acromioplasty and debridement. The patient started therapy on 3/12/07. The physical therapy progress note of 5/3/07 indicates that the patient was still having pain at the sternoclavicular joint region and pain with overhead reaching. There was noted to be a mild reduction in range at the shoulder, and strength was 4 to 4+/5 in the different muscle groups. The note also indicates that the patient appears to have plateaued secondary to pain. Nerve conduction studies were done on 5/2/07 due to apparent concerns for cubital tunnel syndrome. All studies were normal. The physician note of 4/16/07 states that the patient will be seen in follow up in three weeks, and if the electrodiagnostic study is negative, the patient will be released to full duty. When the patient was seen again on 5/7/07 the note indicates that the physician would like to have the patient in for four more weeks of therapy and then discharge him. The patient at that point already had 20 therapy sessions. There was a denial of coverage for further therapy. On reconsideration the denial was upheld, as

the therapy notes were felt to be non-readable, and the reviewer was unable to reach the provider and to speak with him.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

This reviewer is in agreement with the prior denials, and upholds the denials. The physical therapy note of 5/3/07 indicates that the patient has reached a plateau with therapy, most likely secondary to pain preventing the patient from making further gains with strength and range of motion. Based on the statement there would be no medical necessity or appropriateness for further therapy unless the pain was controlled, there is no documentation of any plan for pain management others than iontophoresis. This is noted in the physician prescription and progress note of 5/7/07. ODG guidelines note that iontophoresis is not recommended. The current evidence on Galvanic current (direct or pulsed), iontophoresis, TENS, EMS, PEMF and permanent magnets is either lacking, limited, or conflicting. Iontophoresis is the use of electromagnetic force (0.5 mA to 20 mA) to enhance percutaneous absorption of a drug or chemical, such as dexamethasone, to relatively shallow depths (up to 10 mm). (Kroeling-Cochrane, 2005). As there is no literature support for the efficacy of this treatment for the patient's pain problem, and there is no other management approach suggested for management of the patient's pain problem, there would be no rationale for continuing therapy since the patient already had plateaued because of the pain problem.

In regards to the number of therapy sessions appropriate, ODG guidelines note that for "Rotator cuff syndrome/Impingement syndrome: Post-surgical treatment, arthroscopic: 24 visits over 14 weeks". This patient already had 20 therapy sessions. The request is for another eight sessions, which would take it beyond the ODG guidelines. It should also be noted, that other than the pain problem, there is no indication of any other problem which would prevent the patient from continuing with his therapy program as an independent home exercise program. The request exceeds guidelines and, as noted above, the documentation would not support the medical appropriateness or necessity for the requested additional eight therapy sessions.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Clinical review

OFG Guidelines at:

<http://www.odg-twc.com/odgtwc/shoulder.htm#ProcedureSummary>

<http://www.odg-twc.com/odgtwc/neck.htm#Iontophoresis>