

MEDICAL REVIEW OF TEXAS

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DATE OF REVIEW: **JUNE 4, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy modalities, extremity adjustment

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

Doctor of Chiropractic

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

1. Treating doctor's request for pre-authorization of requested services, dated 3/30/07
Carrier non-authorization for requested services, dated 4/5/07
2. Treating doctor's request for reconsideration of denied requested services, also dated 3/30/07, but stamped "request for reconsideration"

3. Carrier non-authorization for reconsideration of requested services, dated 5/9/07
4. Statement of position by the part of the treating doctor, dated 4/18/07
5. Treating doctor's intact forms, history forms, examination forms, diagnosis form, and DWC-73, all dated 3/23/07
6. Treating doctor's re-examination form, dated 4/24/07
7. MRI report, right shoulder, dated 5/2/07
8. Treating doctor's daily notes, (3/23/07 through 5/4/07) (13 visits)
9. Various DWC-73s

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is male who, on xx/xx/xx, fell out of a truck and injured his right shoulder. He eventually presented to a doctor of chiropractic for conservative management and received approximately 13 visits of passive physical therapy and manipulation. He did not lose any time from work.

In early May, an MRI was performed that revealed "an extensive full thickness tear involving the middle and posterior segments of the supraspinatous tendon," and a "mild partial thickness tear of the articular surface of the anterior margin of the infraspinatous tendon." The treating doctor then requested an extension of his passive therapeutic regimen.

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

According to the medical records submitted for review, the reexamination (dated 4/24/07) indicated that the patient no longer had any pain in his right shoulder. In fact, the rationale for continued care related to continued deficits in the claimant's right shoulder range of motion, and a persistent "popping" sound that was elicited with lateral abduction, both conditions that would respond more readily to an active regimen of care than a passive one. Also, ultrasound is more appropriate for acute, inflammatory conditions, so the medical necessity for continued performance of this procedure is unsupported. Furthermore, neither the initial examination nor the reexamination documented the presence of muscular spasticity that would warrant the utilization of massage. Likewise, the performance of this procedure is also unsupported as medically necessary.

Finally, Section 413.011, Labor Code, provides that the DWC must use the reimbursement policies and guidelines promulgated by the system. The "Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injuries" Reimbursement Policies applicable to the system provide as follows: "It is expected that patients undergoing rehabilitative therapy for musculoskeletal injuries in the absence of neurological compromise will transition to self-directed physical therapy within two months...Only the more refractory cases requiring additional therapy are expected to continue beyond this point and additional documentation of necessity and medical certification by the supervising physician is required." In this case, the claimant has exceeded the recommended two months of active care established by the Policies. Since no documentation was submitted establishing either (a) objective proof of neurological compromise; or (b) that this is a refractory case, the medical necessity of the treatment cannot be supported.

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
 - * **MEDICARE GUIDELINES:** "Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and/or Injures"
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)