



Specialty Independent Review Organization

AMENDED REPORT 5/1/08  
**Notice of Independent Review Decision**

**DATE OF REVIEW:** 4/23/2008

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

The item in dispute is the prospective medical necessity of physical therapy 2-3 times a week x 4 weeks (8 to 12 sessions).

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

The reviewer is a board certified Orthopedic Surgeon who has been practicing for greater than 10 years.

**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)

The reviewer agrees with the previous adverse determination regarding all physical therapy sessions.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Surgery Group and Center - Dr.

These records consist of the following (duplicate records are only listed from one source): Records received: Employer's First Report of Injury-; TWCC73s; Dr. Physician orders and statement-1/30/08-1/23/08, Therapy referral-1/23/08; Dr. MRI of left shoulder report-1/26/08; Dr. Ct scan report-1/23/08; Dr. report-1/21/08; Pre-authorization denial-2/14/08.

Records received from: Pre-authorization denial-3/28/08 & 4/7/08, Pre-authorization Intake form-3/25/08 & 3/31/08; Dr. report for -3/28/08; Dr. Therapy referral-3/17/08, Office notes - 3/17/08-314/08.

Records received from Surgery Group and Center -Dr. Daily Progress notes - 3/12/08-2/22/08. A copy of the ODG was provided by the URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured in a motor vehicle accident while on the job. She sustained injuries to the shoulder and cervical spine. She reported a stiff neck, dizziness and a headache.

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

The reviewer states that based on the documentation provided, the patient has reached a plateau with regards to the cervical spine injury so no more treatment for the cervical spine injury is indicated. However, the documentation provided by Dr. reveals clinical evidence of persistent subacromial impingement or rotator cuff tendonitis. The ODG supports utilization of physical therapy for the shoulder pain.

“ODG Physical Therapy Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Medical treatment: 10 visits over 8 weeks”

There is no documentation that indicates that more than 9 treatments have been offered for the injury. The oldest physical therapy note on 2/22/08 is a follow-up visit which implies that the patient had at least one visit prior to that date.

The patient has therefore undergone at least 9 out of the 10 ODG recommended treatments. However, secondary to DWC policy, we must approve or deny based upon the requested amount of services. 8-12 PT visits is not medically necessary according to the ODG; therefore, the services are denied.

**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)**