



Amended May 15, 2008

### REVIEWER'S REPORT

**DATE OF REVIEW:** 05/10/08

**IRO CASE #:**

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

Physical therapy

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

D.C., D.O., M.S., Board Certified in Chiropractic, Physical Medicine and Rehabilitation, Pain Management

**REVIEW OUTCOME:**

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**

1. I reviewed notes pertaining to a visit on 09/10/07 with Dr. where there was reference made to an injury dated xx/xx/xx to this xx-year-old male. The injury was to his left shoulder and his knees. He had apparently fallen at work.
2. I reviewed additional followup notes from Dr. dated 09/12/07.
3. There was an MRI scan of the left shoulder, which showed “degenerative joint disease in the acromioclavicular joint with evidence of shoulder impingement, mild degenerative changes in the glenohumeral joint, no definite evidence of a full thickness tear of the rotator cuff tear.” This was signed by Dr.
4. I reviewed a note dated 10/08/07 from Dr.
5. I reviewed a note dated 10/09/07 note where he started physical therapy at the Orthopedic Surgery Group.
6. I reviewed the physical therapy notes from physical therapist through 11/09/07.

7. I reviewed a 01/02/08 note from Dr. where he was still complaining of pain in one of his knees and his left shoulder.
8. There was a continued physical therapy note after that through 01/31/08.
9. On 03/03/08 he saw Dr. again.
10. He was seen by Dr. at the Orthopedic Group on 03/12/08 with bilateral knee pain and left shoulder pain. He was told he had left shoulder tendinitis that evolved into a frozen shoulder. He has had cortisone injections into his knees.
11. There was a note from Dr. dated 03/26/08 where he was still having complaints in his left shoulder. He was diagnosed with adhesive capsulitis.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

This is a xx-year-old male who fell, injuring both knees and the left shoulder on xx/xx/xx. The knees were injected with steroids. He was put into therapy. He ultimately had an MRI scan of the left shoulder as noted above. He developed adhesive capsulitis. He has had physical therapy, but it is not clear how many sessions of physical therapy he has actually undergone since the diagnosis of adhesive capsulitis was made. The ODG Guidelines do support sixteen visits of adhesive capsulitis, and I would suggest that it would be appropriate following the diagnosis of adhesive capsulitis. However, once again, it is not clear from the records how many sessions he has actually undergone.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

It does not appear there is need for therapy to his knees. His left shoulder does appear to have reduced mobility compatible with an adhesive capsulitis diagnosis. The ODG Guidelines do recommend up to sixteen sessions of physical therapy for that diagnosis. The reviewer finds that the requested services are reasonable and necessary considering the patient's condition and that the request is within the ODG guidelines.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

*(Check any of the following that were used in the course of your review.)*

- 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 judgment, 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 national accepted medical literature (provide a description).

\_\_\_\_\_Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)