

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: MAY 2, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Additional physical therapy, two to three times per week for four weeks.

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

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination, 03/31/08,
Adverse Determination, 03/19/08
Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, (shoulder, physical therapy)
Office note dated 03/13/08 from Dr.
Fax referral dated 03/18/08
Therapy note 03/18/08
Fax request for physical therapy 03/27/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female, with a date of injury on xx/xx/xx when at work she was lifting a 24 pack of bottled water and as she was flipping the case, she felt a pop in the right shoulder. She was diagnosed with rotator cuff syndrome of the right shoulder and with biceps tendinitis. The doctor recommended an injection followed by therapy to alleviate the shoulder pain. The only therapy note stated the claimant had pain in the acromio-clavicular joint and subacromial bursa, and was recommended to have occupational therapy two to three times a week for four weeks. A peer review was completed on 03/19/08 that denied the request for continuation of physical therapy. A second peer review was completed 03/31/08 that also denied the request for continuation of physical therapy.

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

The question posed is the medical necessity for additional physical therapy two to three times per week. The patient is a female whose date of injury was listed as xx/xx/xx. This case had been reviewed by Dr. who did not feel further therapy was indicated as well as Dr. on 03/31/08 who also felt that further therapy was not indicated. It appears that the patient has already had therapy at some time in the past, but the degree of therapy was not documented in the records provided. Based upon the medical records and other information provided for review, and based on the ODG physical therapy guidelines, the reviewer finds that there is not medical necessity for additional physical therapy, two to three times per week for four weeks.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, (shoulder, physical therapy)

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.

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

1. Medical treatment: 10 visits over 8 weeks
2. Post-injection treatment: 1-2 visits over 1 week
3. Post-surgical treatment, arthroscopic: 24 visits over 14 weeks
4. Post-surgical treatment, open: 30 visits over 18 weeks

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)**