

Applied Assessments LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: 05/04/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 visits of Physical Therapy to the left shoulder using 97014/G0283 (e-stim), 97035 (ultrasound), 97110 (therapeutic exercises), 97140 (manual therapy techniques), and 97530 (therapeutic activities)

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)

Upon independent review the reviewer finds that the requested 12 visits of Physical Therapy to the left shoulder using 97014/G0283 (e-stim), 97035 (ultrasound), 97110 (therapeutic exercises), 97140 (manual therapy techniques), and 97530 (therapeutic activities) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 04/01/08, 04/07/08, 04/16/08
ODG Guidelines and Treatment Guidelines
Evaluations, 04/14/08, 03/24/08, 03/17/08
Peer Review Reports, 03/28/08, 04/04/08, 04/14/08
Request for Reconsideration, 04/03/08

Therapy Referral, 03/24/08
Evaluation/Plan of Care, 03/24/08
Work Status Report, 04/14/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is injured worker who, according to history, fell onto his shoulder and also fractured his ribs while at work. He is a xxx by trade and fell off a ladder from a height of about sixteen feet. He apparently fractured three right ribs and his nose. He injured his left elbow, shoulder, and both knees. He had some physical therapy and a steroid injection into his joint. On 4/14/08 the decision was made for him to undergo surgery. The current request is for 12 visits of Physical Therapy to the left shoulder using 97014/G0283 (e-stim), 97035 (ultrasound), 97110 (therapeutic exercises), 97140 (manual therapy techniques), and 97530 (therapeutic activities).

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

The request for 12 visits of Physical Therapy with the aforementioned modes of treatment is not medically necessary. This is an injured worker who is already scheduled for surgery. Hence, the request for physical therapy preoperatively at this time is not medically necessary. Furthermore, the request for twelve visits of physical therapy to the left shoulder exceeds ODG Guidelines. ODG Guidelines support only ten sessions of physical therapy for this particular diagnosis. Additionally, electrical stimulation is not recommended, ultrasound is only recommended for calcific tendinitis, which is not his diagnosis, exercise is recommended, manual therapy may be helpful and therapeutic exercises are part of the program.

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)