

# I-Decisions Inc.

*An Independent Review Organization*

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## Notice of Independent Review Decision

**DATE OF REVIEW: SEPTEMBER 12, 2008**

**IRO CASE #:**

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

Twelve (12) Additional Physical Therapy Services

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for Twelve (12) Additional Physical Therapy Services.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 8/13/08, 8/20/08

ODG Guidelines and Treatment Guidelines

MD, 1/22/08, 1/29/08, 2/19/08, 3/6/08, 3/25/08, 4/17/08, 4/22/08, 5/6/08, 5/20/08, 7/22/08

MRI of Cervical Spine, 6/10/08

PT, 7/29/08

MRI Upper Extremity, 11/19/07

MRI of Cervical Spine, 3/14/-07  
Cervical Spine, 3 Views, 3/6/07  
MD, 3/9/07, 3/6/07  
FCE, 7/12/07  
MD, 6/25/07  
EMG, 6/25/07  
PT Notes, 2007-2008

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This is an injured worker, xx years old, injured on xx/xx/xx, who apparently had physical therapy from 03/07 until 05/22/07 without much benefit. She has had x-rays of the shoulder, which were reported as normal, and MRI scan of 06/10/08 which was reported showing a bulging disc at C4/C5, C5/C6, and C6/C7. She had an MRI scan of the right shoulder, which was reported as being normal. She had approximately three months of therapy in 2007 and recent therapy completed in 2008, twelve further visits, according to the medical records. She has a possible biceps tendinitis and carpal tunnel syndrome that was resolved with injection and questionable complaints related to the neck.

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

Based upon ODG Guidelines, the absence of a diagnosis for the shoulder and no evidence in the medical record of further medical necessity for physical therapy with a normal MRI scan and questionable physical findings with multiple complaints in the neck and shoulder without an underlying objective diagnosis, this reviewer finds that previous adverse determination for lack of medical necessity should be upheld. The reviewer finds that medical necessity does not exist for Twelve (12) Additional Physical Therapy Services.

**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)**