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Notice of Independent Review Decision

DATE OF REVIEW: 12/7/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The disputed service involves six sessions of physical therapy (rehabilitation) consisting of 97110, 97140 and 97122.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer 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 the prospective medical necessity of six sessions of physical therapy (rehabilitation) consisting of 97110, 97140 and 97122.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
MD and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: 11/23/09 letter from Dr., 11/2/09 request for reconsideration letter and 10/23/09 PT progress note.

Records reviewed from: 10/29/09 nonauthorization letter, 11/12/09 reconsideration non-authorization letter, computer screen printouts from 6/1/09 to 11/12/09, 6/1/09, 7/13/09, 8/20/09, 9/11/09, 9/21/09 and 10/26/09 and 11/5/09 preauth requests from Clinic, PT eval of 5/29/09, PT progress notes from 7/13/09 to 9/8/09, 7/13/09 letter by RN, initial consult notes Dr. of 5/29/09, 8/10/09 and 10/23/09 consult reports by MD and a 9/18/09 request for reconsideration letter.

We did not receive the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient, while working, noted pain in the left shoulder while closing a door . The patient sought treatment from MD. He received conservative treatment with physical medicine modalities and exercise, medications, and referral to orthopedist, MD. Dr. recommended exercise, medication, and injections. Surgery was not recommended. The patient has responded with increased ROM in the shoulder and reduction, but not complete elimination of, shoulder pain. The patient is reported to have declined a recent offer of further shoulder injections due to the patient's fear of injections.

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

According to the 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

Adhesive capsulitis (IC9 726.0):

Medical treatment: 16 visits over 8 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

The patient has failed to meet ODG criteria for Internal Derangement Shoulder. The ODG would support up to 16 treatment sessions of physical therapy. The documentation provided for this review indicates that the patient has had at least 30 treatment sessions. Therefore, proposed treatment is not medically necessary according to the ODG.

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)**