

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 7/7/2009  
**IRO CASE #:**

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

1. Physical therapy 3 x week for 4 weeks (97110, 97010, G0283, 97035, 97124, 97140, 97116, 97530)

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from University of Missouri-Kansas City and completed training in Physical Med & Rehab at Baylor University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 2006 and Pain Management since 2006.

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- |   |                                  |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld    | (Agree)                          |
| <input type="checkbox"/> Overturned           | (Disagree)                       |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

1. Physical therapy 3 x week for 4 weeks (97110, 97010, G0283, 97035, 97124, 97140, 97116, 97530) Upheld

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a xx year old male who presented with neck and left shoulder pain. There is also numbness and tingling of the 4th and 5th digits. There is tenderness and decreased neck and shoulder motion in the neck and shoulder. A cervical MRI showed mild spondylosis and left shoulder MRI showed tenosynovitis of the biceps tendon.

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

The injured employee is a xx year old male who presented with neck and left shoulder pain after date of injury xx/xx/xx. The worker reported a witnessed injury having been struck about the left neck/shoulder area by a falling box of eggs. There is also numbness and tingling of the 4th and 5th digits. There is tenderness and decreased neck and shoulder motion in the neck and shoulder. A cervical MRI showed mild spondylosis and left shoulder MRI showed tenosynovitis of the biceps tendon, suspected contusion with neck and shoulder strain and brachial plexus stretch injury. He was initially approved for a trial of 6 PT sessions and subsequent request was made for 12 additional PT sessions and associated modalities and is now in appeal. Prior denial on 5.28.2009 reasoned the patient attended the ODG recommended trial of therapy without significant progress and therefore there was inadequate reason for 12 additional therapy sessions in excess of ODG recommendations. In the second denial on 6.5.09 the second peer reviewer notes that the PT was noting the patient's progress with PT had been marginal and the patient has not done well with PT. Other treatments include oral medications Darvocet, naproxen, shoulder injection, NMES, and form fitting conductive garment. PT reevaluation notes on 5.21.2009 note the recommendation to await EMG/NCS before progressing with more PT, patient had completed 4 of 6 sessions at that time but a new order for PT was received on 5.15.09 for TIW for 4 weeks. EMG/NCS on 6.1.2009 was WNL. A shoulder injection was done on 6.5.09 and an FCE ordered.

The recommendation is to uphold the prior denials. It appears from the records the patient has had 4 sessions to date of PT. A new request was received for 12 additional therapy sessions. The patient has not been doing well with recovery in spite of traditional treatment and appropriate work up. An FCE has been ordered. Physical therapy medical treatment of cervical sprains is recommended for 10 visits, whereas brachial neuritis is recommended at 12 visits, and shoulder injuries carry similar recommendations. Given that the patient has not progressed well with therapy to date and the newly requested number of sessions plus 4 sessions to date are beyond ODG recommendations approval for 12 more sessions of PT is not considered medically necessary.

**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

**X** 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)