



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 11/20/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 3 x Wk x 4 Wks for the right shoulder (97010, G0283, 97140, 97110, 97113).

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 and performs this type of service in daily practice.

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 all services under review.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
WC Services and MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from WC Services: Denial letters – 10/5/09 & 10/30/09; faxed pre-authorization request – 9/30/09, Initial Plan of Care Physical Therapy, Outpatient Clinical Assessment, & UE Assessment Addendum – 9/30/09, Reconsideration request – 10/27/09; MD PT script – 9/18/09. Records reviewed from MD: Office Note – 9/18/09; MD MRI report – 8/17/09.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to records, this patient was injured on xx/xx/xx. The record from his current treating physician, M.D., dated September 18, 2009 indicated that the patient had injured his shoulder at work. Dr. clearly states that he “has not received any treatment to this point in time” although prior independent reviews indicate that the patient had undergone conservative management including physical therapy and medications. Dr. ’s note indicates that he was complaining of tenderness and activity related pain in the shoulder. Dr. ’s note indicates that the patient had not been working since his injury and that he was taking hydrocodone 10 mg for pain. He indicated that he had not been taking any anti-inflammatory medications and stated that he denied neck or radicular symptoms. Dr. ’s evaluation demonstrated tenderness over the acromioclavicular joint and greater tuberosity, limited range of motion of the shoulder, and positive Neer and Hawkins signs.

Dr. ’s note indicates that x-rays showed a type II acromion. A MRI demonstrated degenerative changes in the acromioclavicular joint as well as impingement and partial thickness, articular surface tear of the supraspinatus tendon with a grade II subscapularis strain.

Dr. ’s initial assessment was that the patient had “right shoulder pain and impingement.” Dr. performed an injection of the shoulder with Depo Medrol and Lidocaine and ordered physical therapy two to three times a week for six weeks.

An initial plan of care of physical therapy and a physical therapy evaluation indicated that he had limited range of motion of his shoulder and the plan of treatment included modalities, exercise, and a home exercise program. A RME report from M.D. and a report from MD appear to confirm that no prior treatment (Physical Therapy, injection, surgery) had been provided for the shoulder injury.

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

Notes from independent reviews indicate that he did receive therapy although that therapy may have been provided for his lower back and not his right shoulder. Physician’s notes clearly indicate that the right shoulder had not been previously treated. Dr. ’s evaluation indicated that he has shoulder pain and impingement. According to the ODG Guidelines, initial treatment for this problem should include alteration of activity, appropriate analgesia, and/or anti-inflammatory medications. The patient altered his activity and has not worked since his injury. He has been taking Norco for pain. Subsequent treatment, according to the ODG Guidelines, may include physical therapy for three visits for two weeks. He has been treated conservatively with rest, analgesics, and injection. He has also started a physical therapy program. The physician’s

prescription for physical therapy 2-3 times a week for 6 weeks would meet ODG Guidelines, but the IRO has been requested to review physical therapy three times a week for four weeks which exceeds that allowed in the Guidelines. The ODG indicates physical therapy three times a week for two weeks followed by active therapy up to two visits per week is acceptable. Because this request falls outside of the generally acceptable protocol, this request is denied at this time.

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)