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Notice of Independent Review Decision

AMENDED REPORT 11/11/2009

DATE OF REVIEW: 11/10/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include physical therapy to the lumbar spine and left shoulder consisting of 97110 (3 units per session), 97140 (1 unit per session) and 97032 (1 unit per session) on a frequency of 3 times 4 weeks.

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

The reviewer is a Doctor of Chiropractic who has been practicing for greater than 15 years. This reviewer performs similar services in his office.

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 physical therapy to the lumbar spine and left shoulder consisting of 97110 (3 units per session), 97140 (1 unit per session) and 97032 (1 unit per session) on a frequency of 3 times 4 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: office notes by MD of 5/27/09 to 9/8/09, office notes by DC 6/19/09, office notes by Dr. 8/20/09 to 10/20/09.

7/23/09 denial letter, 8/26/09 denial letter, 10/23/09 IRO summary, DWC 1 form dated 6/5/08, 1 pg associate statement (undated), notes from and Dr. 6/5/08 to 6/9/08, office notes by Dr. 6/12/08 to 4/20/09, apparent therapeutic notes of 6/13/08 to 7/22/08 and 3/18/09 to 3/21/09, SOAP notes 6/13/08 to 10/6/09, off work note 7/8/08, 7/9/08 radiographic report of Left Shoulder and lumbar spine, 7/9/08 lumbar MRI report, 8/19/08 report by MD, 10/1/08 to 1/22/09 notes by Dr., various DWC 73 forms, 12/17/08 to 1/19/09 reports by, DC, FCE report of 3/27/09, 8/26/09 confidential report from LLC, preauth request form 8/21/09 and 7/21/09 and a PT prescription (7/8/09) from Dr..

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

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker was injured while working. The accident report indicates he was injured in the furniture department. He measured 5' 5" and weighed 150 pounds at the time of accident. The latest notes by Dr. indicate he is 5'5" and weighs 166 pounds with hypertension and lumbar/left shoulder pain of a 5/10 nature.

He has been recommended for surgery according to the records; however, the patient has reportedly denied wanting the surgery to this point. Rehabilitative services have been performed in the summer of 2008 through Dr. The MRI reports a L4/5 3mm protrusion which contacts the nerve root at this level. Also noted is a 1-2mm L5/S1 protrusion which is noted to contact the S1 nerve root bilaterally. Multi-level disc degeneration is noted to be present from L2 to L5.

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

The rehabilitative notes provided from the Clinic do not indicate how the patient is doing during the therapeutic process. The SOAP note of the same date xx/xx/xx indicates one should review the progress sheet; however, the progress sheet does not indicate the patient is progressing in number of sets, reps or weight/band strength. In fact, the patient continued doing the following exercises since day one of rehab (wall shoulder, theraband and williams' low back exercises). On 7/22/08, apparently codman's exercise was introduced. It is the reviewer's opinion that this exercise is better used in the beginning stages of a shoulder rehab program not three to four weeks into the program.

According to the FCE in March of 2009, he was at a medium PDL which matched his job description. There were restrictions imposed by Dr.; however, the reviewer notes that the patient did not improve significantly with physical therapy maneuvers in the last sessions; therefore, it is not likely a significant change can or will occur during the requested sessions.

The ODG indicates the following as the criteria for PT: Lumbar sprains and strains (ICD9 847.2): 10 visits over 8 weeks

Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8): Medical treatment: 10 visits over 8 weeks

As it relates to the shoulder the same guides indicate the following criteria:

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

This patient has determined not to follow through with the surgical recommendations; therefore, he does not qualify for the surgical treatment rehabilitative option. Secondly, he is outside of the range of the medical treatment based upon his lack of response to the initial offering of treatment in 2008 and early 2009. Due to the lack of response, ODG criteria and the reviewer's professional chiropractic opinion this treatment is denied as not medically necessary 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)**