IMED, INC.

11625 Custer Road · Suite 110 – 343 · Frisco, Texas 75035
Office 972-381-9282 · Toll Free 1-877-333-7374 · Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 09/30/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 9 physical therapy visits over 3 weeks using #97140, #97014, #97035, and #97110

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

Board Certified Physical Medicine & Rehabilitation
Fellowship Trained Pain Management

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Cover sheet
2. Office notes from D.C., chiropractor
3. Thoracic, AP, lateral and swimmers x-ray, 10/09/08
4. X-ray left shoulder, 10/09/08
5. X-ray right shoulder, 10/09/08
6. MRI of the left shoulder – pre and post contrast, 11/19/08
7. MRI of the right shoulder – pre and post-contrast, 11/19/08
8. Office notes from neurology
9. Required medical examination from, M.D., 05/12/09
10. Office Note M.D., pain management
11. Previous determination
12. Previous reviews, 08/21/09, 08/31/09
13. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

We begin with medical records on 08/08/08 from, D.C. At that time, it was noted that the employee was in need of a follow-up appointment. She continued to report symptoms of neck pain and upper extremity symptoms. She had previously received authorization for treatment for the appointment but was unable to make it.

On 09/03/08, there was a follow-up with Dr.. The original date of injury was noted as xx/xx/xx. The primary complaint on that date was bilateral shoulder pain which had become quite a problem and her pain level was 6-8/10. She could only sleep on her back because if she rolled onto her shoulders, the pain became unbearable. She also noted neck pain as well, and the most pain was noted in the posterior aspect of the neck and the trapezius muscles. Upon evaluation, the employee had weakness in her grip bilaterally, worse on the left than right graded at 4/5. There was negative Tinel's and negative Phalen's in each wrist. Vibration perception was equal. Compression procedures showed pain bilaterally. There was weakness testing in both shoulders, left greater than right. It was recommended that the employee have repeat MRIs of the bilateral shoulders. It was noted the employee had been through arthroscopic procedures in the past and a modified Mumford procedure on both shoulders. Additional referral to pain management was discussed. The plan was to follow-up afterwards.

X-rays of the thoracic spine were taken on 10/09/08 which revealed normal alignment of the thoracic spine with minimal spondylosis and endplate changes throughout. No evidence of fracture, subluxation, compression, or deformity was noted.

X-rays of the left shoulder was taken on 10/09/08 and revealed widening of the left AC joints suggestive of probable old injury with diastasis. The study was otherwise unremarkable.

X-rays of the right shoulder were taken on 10/09/08. This showed prior rotator cuff repair and a narrowed subacromial space. There was no fracture or dislocation identified. No significant degenerative arthrosis at the glenohumeral or AC joints was noted.

On 10/21/08, the employee returned for follow-up with Dr. On that date, she had limited range of motion in both shoulders with flexion being limited about 85% and very painful. Abduction appeared to be slightly worse than the previous visit. There was fixated motion at the cervical thoracic junction noted. It was noted that Dr. opined further MRIs were still needed.

On 11/19/08, an MRI of the left shoulder pre and post contrast was performed. This study revealed status post acromioplasty and Mumford procedure with no residual outlet stenosis, large subacromial bursal effusion, no evidence of recurrent rotator cuff tear, and mild shoulder joint osteoarthritis. An MRI of the right shoulder was taken on that same date that showed status post acromioclavicular and supraspinatus tendon repair. There was no evidence of recurrent rotator cuff tear, tendinosis or flattening of the

subscapularis tendon with tendon sheath effusion consistent with tenosynovitis, mild shoulder joint osteoarthritis with focus of anterior lateral detachment versus enlarged sublabral foramen, and diffuse free edge fraying throughout the labrum.

A neurology visit occurred on 02/19/09. The diagnosis at that time was recurrent low back pain with spasms and local spread, recurrent posterior cervical pain with spasm and local spread, recurrent shoulder pain, and carpal tunnel syndrome. Current medications included Celebrex and Lyrica. Cranial nerves 2-12 were intact, sensation was unimpaired, and reflexes were physiologic and equal. Motor systems showed weakness of the opponens pollicis and opponens digiti quinti muscle, as well as grip right and left reversed on the volar wrist compression maneuver. Marked limitation in neck range of motion was noted on either side with spasm and tenderness. There was tenderness over the scapular and trapezius areas and tenderness over the lower lumbosacral junction. Hip, shoulder, and girdle maneuvers were not performed. Straight leg raise test was positive bilaterally at 70 degrees. The impression was lumbosacral osteoarthritis and spondylosis with apparent associated disc herniation at L5-S1. Cervical pathology at C5-6 and C6-7, disc herniation which was previously surgically treated, and bilateral carpal tunnel syndrome mild to moderate were noted. The plan was no indication for additional diagnostic studies, and medication to include Celebrex and Lyrica.

A Required Medical Evaluation (RME) occurred on 05/12/09 by Dr. At that time, it was noted that Celebrex and Lyrica appeared reasonable and necessary, and treatment duration was indefinite at that time.

Follow-up occurred on 08/17/09 with Dr.. The clamant noted the employee had a rather significant flare-up that caused her neck to lock up and become very stiff over the weekend. She was doing a little better on that date. She reported it started in the lower neck and radiated to the right scapula. Evaluation showed equal perception of vibration in the upper extremities. There was some altered sensation, and reflexes were 2+ and brisk in the upper extremities. Grip strength was slightly weak and symmetrical. Compression procedures to the head and neck were painful, especially when her neck was bent lateral or rotated to the left. There was also noted spasm at the cervical and thoracic junction. The plan was to refer to pain management.

On 09/08/09, the employee was evaluated by Dr. of pain management. The impression at that time was chronic cervical neck pain since the date of accident, right C4-C5 cervical facet arthropathy, status post 5-6 and 6-7 anterior cervical neck fusion, chronic bilateral shoulder capsulitis syndrome, bilateral deltoid bursitis and supraspinatus tendonitis pain, history of bilateral shoulder surgery, bilateral carpal tunnel release, and left cubital tunnel release. Medial branch blocks were discussed at C4-C5 for the facet related disease. Consideration was also made for radiofrequency ablation.

Following this visit, there was a request for nine additional physical therapy visits over three weeks.

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

This employee suffered an on-the-job injury on xx/xx/xx and has undergone multiple surgical interventions and treatments for job-related injuries.

There is currently no clinical evidence that ongoing symptomatic complaints are related to the original on-the-job injury. Current ***Official Disability Guidelines*** support the use of physical therapy in the acute setting, and based on the fact that it has been several years since this employee was last seen by her treating doctor, Chiropractor, there is currently no clinical evidence that the ongoing request for physical therapy is warranted and/or necessary when reviewing the ***Official Disability Guidelines***.

At this time, the decision is to not certify the physical therapy request for 9 physical therapy visits over 3 weeks.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

1. ***Official Disability Guidelines***, Cervical Spine and Lumbar Spine Chapters, on-line version
2. Jensen I, Harms-Ringdahl K. Strategies for prevention and management of musculoskeletal conditions. Neck pain. *Best Pract Res Clin Rheumatol*. 2007;21:93-108.
3. Laxmaiah Manchikanti, MD, Vijay Singh, MD, David Kloth, MD, Curtis W. Slipman, MD, Joseph F. Jasper, MD, Andrea M. Trescot, MD, Kenneth G. Varley, MD, Sairam L. Atluri, MD, Carlos Giron, MD, Mary Jo Curran, MD, Jose Rivera, MD, A. Ghafoor Baha, MD, Cyrus E. Bakhit, MD and Merrill W. Reuter, MD. ***American Society of Interventional Pain Physicians Practice Guidelines***. *Pain Physician*, Volume 4, Number 1, pp 24-98, 2001.
4. Theodore Doege, MD, Thomas Houston, MD, et.al. ***The American Medical Association Guidelines to the Evaluation of Permanent Impairment***, 4th Edition, 4th Printing; October 1999.