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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/28/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 2Wks right shoulder 97113 97140 97112

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE

PROVIDER WHO REVIEWED THE DECISION:

M.D., Board Certified Orthopedic Surgeon

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

04/27/10 MRI cervical spine

05/18/10 Dr., hand written office note

06/02/10 Dr., pain management office note

06/01/10 Dr. request

06/02/10 Dr. peer review

06/09/10 Request for cervical facet medial branch block.

06/18/10 Dr. hand written office note

06/25/10 Dr. office note

06/28/10 Dr. peer review

06/30/10 Dr. request for physical therapy

06/02/10

06/28/10

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapters neck and shoulder

PATIENT CLINICAL HISTORY SUMMARY

This is a male with complaints of neck and right shoulder pain. Date of injury was xx/xx/xx.

On 06/02/10, Dr. stated that the MRI of the cervical spine from 04/27/10 showed a 2 millimeter broad based disc bulge with facet hypertrophy at C3-4, 2 millimeter concentric posterior annular bulge with facet arthropathy at C4-5, 3 millimeter posterior disc bulge at C5-6 and 2 millimeter posterior disc bulge at C6-7. Dr. stated the claimant was pending right shoulder surgery. On 06/01/10, Dr. requested 6 physical therapy visits for the right shoulder. The 06/02/10 peer review documented the 03/31/10 MRI of the right shoulder showed moderate thickening with increased signal involving supraspinatus tendon indicating tendinopathy, no full thickness tear and moderate hypertrophy at the acromioclavicular joint with moderate inferior osteophyte formation. On 06/25/10, Dr. saw the claimant and noted that the claimant was status post selective nerve root block on 06/24/10. There was a complaint of tenderness to palpation to C4-T1 and right triceps strength was 4/5.

Diagnosis was cervical strain versus intervertebral disc and no significant pain reduction following the injection. Dr. requested post injection physical therapy. The 06/28/10 peer

review documented that 9 physical therapy visits were certified but were never completed and the right shoulder surgery was not performed. A 06/30/10 request for physical therapy for the cervical spine was reviewed. Review of the records indicated that the claimant did have physical therapy for the cervical spine. This request is for Physical Therapy 3xWk x 2Wks right shoulder 97113 97140 97112.

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

The evidence-based literature would suggest that most individuals can be successfully rehabbed for non-surgical treatment of rotator cuff pathology and/or cervical soft tissue injuries with up to 10 visits of physical therapy over several months. Most therapies use a variety of active treatments. While there appears to be considerable confusion within the records as to what treatment has been authorized and/or completed to date, therapy was deemed reasonable and medically necessary in June of 2010. Based on the records provided, the reviewer finds that medical necessity exists for Physical Therapy 3xWk x 2Wks right shoulder 97113 97140 97112.

Official Disability Guidelines Treatment in Workers' Comp 2010 updates, chapters neck and shoulder

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

Medical treatment: 10 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0)

10 visits over 8 weeks

Active Treatment versus Passive Modalities: See the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral.

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

ACOEM-AMERICA 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)