



Medwork Independent Review

5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
Fax: 715-552-0748
Independent.Review@medworkiro.com
www.medwork.org



NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)

12/02/2010

DATE OF REVIEW: 12/02/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 physical therapy visits with re-evaluation

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

Texas State Licensed MD Board Certified Occupational Medicine physician

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Texas Dept of Insurance Assignment to Medwork 11/15/2010
2. Notice of assignment to URA 11/15/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 11/12/2010
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 11/11/2010
6. Letter 11/11/2010, letter 10/11/2010, 10/05/2010, medical note 10/21/2010, 09/27/2010, referrals 09/27/2010, medical note 09/23/2010, 07/07/2010, 04/16/2010, 03/19/2010, 02/19/2010, 02/10/2010, 01/26/2010, 10/20/2009, 10/13/2009, MRI 10/16/2009
7. ODG guidelines were provided by the URA

PATIENT CLINICAL HISTORY:

This is a man who reported pain in his left shoulder while lifting heavy objects at work on xx/xx/xx. He denied any history of a click or a pop in the shoulder at the time of incident. On examination, he was noted to have decreased range of motion with possible signs of impingement. He was diagnosed with the left shoulder sprain and was prescribed physical therapy for the relief of the symptoms. The patient's symptoms were, however, not fully resolved. He underwent an orthopedic evaluation. Based on assessment, he was treated with an intra-articular cortisone injection and was recommended



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additional physical therapy. The patient reported minimal relief in his symptoms and continued to have restricted range of motion and decreased muscle strength of the shoulder.

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

As per ODG Guidelines: 10 physical therapy visits over 8 weeks are recommended for sprains and strains of shoulder. ODG physical therapy guidelines for rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.120), 10 visits over 8 weeks are recommended for medical treatment; 1-2 PT visits over 1 week are recommended as post-injection treatment. Sprain and strains are self-limiting conditions; majority of them are resolved within few weeks with some palliative measures. Generally, PT is considered beneficial in the early phase of the sprains and strains. If a patient does not show significant improvement in this phase it is unlikely to be beneficial in the chronic phase. This patient suffers from left shoulder pain with possible signs of impingement. He has been treated with 8 visits of physical therapy (2 missed appointments) and a cortisone injection to his shoulder. However, he had failed to show significant improvement with the current medical treatment. He continued to have limited functional capacity due to moderate pain, restriction of range of motion, muscle spasms and decreased strength of the joint. Thus, it is not clear how additional physical therapy would help in further improving his clinical condition; therefore, based on the ODG guidelines and the records reviewed, the insurer's decision to deny the request for 12 physical therapy visits with re-evaluation is upheld.

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 KNOWLEDGBASE
- AHCP- 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



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FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)