

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 2/1/2010  
**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

97110 Adult Post-op Physical Therapy Right Shoulder x12 Sessions; 3 Units per Session  
97140 Manual Therapy Right Shoulder x 12 Sessions; 1 Unit per Session

**QUALIFICATIONS OF THE REVIEWER:**

This reviewer graduated from University and completed training in Physical Med & Rehab at University Medical Center. A physicians credentialing verification organization verified the state licenses, board certification and OIG records. This reviewer successfully completed Medical Reviews training by an independent medical review organization. This reviewer has been practicing Physical Med & Rehab since 7/1/2006 and Pain Management since 9/9/2006. This reviewer currently resides in TX.

**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)

97110 Adult Post-op Physical Therapy Right Shoulder x12 Sessions; 3 Units per Session  
97140 Manual Therapy Right Shoulder x 12 Sessions; 1 Unit per Session Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Letter by, dated 1/13/2010
  2. Independent review dated 1/13/2010
  3. IRO request form dated 1/11/2010
  4. Request form dated 1/8/2010
  5. Review outcome dated 12/15/2009
  6. Letter by author unknown, dated 12/2/2009
  7. Retrospective review dated 9/22/2009 to 12/23/2009
  8. Review outcome dated 5/13/2009
  9. Review determination dated 1/30/2009
  10. Review determination dated 1/21/2009
  11. Member profile request dated 8/2/2006
  12. Review determination dated 7/26/2006
  13. Notice of disputed issue dated 7/19/2006
  14. Exit interview dated 9/1/2005
  15. Letter by MD, dated 6/15/2005
  16. Review of medical history dated 6/15/2005
  17. Impairment rating report dated 6/15/2005
  18. Form by author unknown, dated 5/23/2005
  19. Work status report by author unknown, dated 4/20/2005
  20. Letter by MD, dated 4/20/2005
  21. Functional capacity evaluation dated 4/15/2005
  22. Capacity evaluation dated 4/12/2005
  23. Form by author unknown, dated 11/22/2004
  24. History form by author unknown, dated 9/13/2004
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25. MRI of the cervical spine by MD, dated 8/16/2004
26. Form by author unknown, dated 8/3/2004 to 5/13/2005
27. Daily progress notes dated 7/29/2004 to 12/27/2004
28. Shoulder examination dated 7/14/2004
29. Account statement dated 7/6/2004
30. MEG/NVC of upper extremity dated 7/6/2004
31. Five reviews of the cervical spine by MD, dated 7/2/2004
32. MRI of the right shoulder by MD, dated 7/2/2004
33. Form by author unknown, dated 6/20/2004
34. Employer's first report dated unknown
35. Notice dated unknown
36. Letter by author unknown, dated unknown
37. Prescription note dated unknown
38. Clinical by author unknown, dated unknown
39. Clinical note by, dated unknown
40. Medical evaluation dated unknown
41. Official Disability Guidelines (ODG)

**INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

The injured employee is a lady injured xx/xx/xx working. She has had treatment since 6/22/2004 of varying types. She injured her right shoulder and had surgery on 5/12/2009. Surgery was a manipulation under anesthesia, arthroscopic subacromial decompression, distal clavicle excision and debridement of posterior-superior labral tear. She was treated with 24 sessions of post operative physical therapy and subsequent 160 hour chronic pain management program 10/09. She is requesting an additional 12 treatment sessions of physical therapy.

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

To date the injured employee has had a copious amount of treatment in both the pre and post operative periods. Postoperatively the injured employee has participated in 24 standard post operative physical therapy sessions followed by 20 day/160 hour chronic pain management program. It is noted in the 12/18/09 office note that the injured employee has had a marked improvement in pain and range of motion compared to prior examinations and FCE's. Injured employee is noted to be compliant with an active home exercise and stretching program. The guidelines state that after a chronic pain program re-enrollment into out-patient medical rehabilitation is not warranted for the same condition or injury. At this point in time the injured employee has been afforded an extensive supervised post-surgical therapeutic treatment program of post standard post op PT and a chronic pain management program. As stated by ODG, the purpose of these programs is to allow the injured employee to become more independent regarding their longterm care and management. At this point in time the injured employee is appropriately independent with her home exercise program. It is unclear what significant improvement in her current functional level is expected to warrant additional therapy after the completion of such extensive treatment since surgery. It is recommended that the prior denials of 12 sessions of physical and manual therapies be 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 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)