



MedHealth Review, Inc.  
661 E. Main Street  
Suite 200-305  
Midlothian, TX 76065  
Ph 972-921-9094  
Fax 469-286-0735

**Notice of Independent Review Decision  
AMENDED REPORT 2/9/2010**

**DATE OF REVIEW:** 2/8/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 12 sessions of therapeutic exercises and manual therapy techniques (97110 & 97140).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years.

**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 the prospective medical necessity of 12 sessions of therapeutic exercises and manual therapy techniques (97110 & 97140).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Management Organization

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Management Organization: Denial Letters – 12/30/09 & 1/12/10; IMO Pre-authorization request forms – 12/21/09 & 1/7/10; EPOSG Therapy Referral – 12/4/09, Evaluation report – 12/17/09, Office Notes –

12/4/09-12/22/09; Email from– 5/14/09; MD Addendum report – 2/6/09; DWC69 – 10/28/08.

A copy of the ODG was not provided by the Carrier or URA for this review.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who was injured on xx/xx/xx. A 12/17/09 dated therapy evaluation progress note denoted that the claimant had undergone shoulder surgery on 3/17/08. Chronic persistent shoulder pain, burning, weakness and dysfunction were deemed attributable to the sternoclavicular subluxation. Active motion included 152 degrees of flexion and 110 degrees of abduction, with reduced motor power and mild SC joint tenderness. Formal occupational therapy was felt indicated. The treating provider's records from 12/4/09 and earlier referenced the aforementioned diagnosis, along with subjective and objective findings. Crepitus at the SC joint and pectoral muscle tenderness were also noted, as was full motion. Arthrosis at the affected SC joint, along with pectoralis inflammation and slight "scapular dyskinesia" were noted by the AP. Therapy and surgery (partial clavulectomy) were considered by Dr. A 2/6/09 dated letter from a Dr. rescinded MMI.

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

The objective physical findings on exam are not significant enough (regarding motion deficit, strength, tenderness, spasms etc.) to warrant other than a prescribed self-administered therapy program. There is no valid rationale provided that would support a resumption of on-going formal supervised therapy.

ODG Guidelines: Physical and/or Occupational Therapy:

"Allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface."

**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)