MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 12/30/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The services under dispute include physical therapy 3x/week for 4 weeks consisting of 97010, 97014, 97035, 97140, 97124, 97110 and 97530.

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 Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 15 years in active practice.

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 medical necessity of physical therapy 3x/week for 4 weeks consisting of 97010, 97014, 97035, 97140, 97124, 97110 and 97530.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Records were received and reviewed from the following parties: Orthopedic and Healthcare.

These records consist of the following:: Initial PT eval by PT 11/13/09 and notes by, MD of 11/2/09.

Orthopedic: notes by Dr. from 1/21/08 to 11/2/09, work conditioning summaries 4/11/08 to 4/25/08, rehab notes from COTA (C Fierro OTR) from 1/23/08 to 3/6/08 and 3/13/08 FCE.

We did not receive a copy of the WC Network Treatment Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This gentleman injured his right shoulder at work on xx/xx/xx. He was trying to keep a piece of sheetrock from falling and felt a sharp pain and pop in his right shoulder. His initial treatment is unclear. There is one mention in the medical record that he had shoulder surgery on April 18, 2007. He apparently had a second surgical procedure on the right shoulder on October 18, 2007 which was an arthroscopic subacromial decompression and biceps tenodesis. He received postoperative therapy.

The note from January 21, 2008 indicates that he was receiving therapy, but was going to change therapists. Notes from January 31, 2008 until March 6, 2008 indicate that he had eleven therapy sessions. He had a Functional Capacity Evaluation performed on March 17, 2008 and a Work Hardening Program was recommended. There are notes in the chart that indicate that he had work hardening therapy for at least ten sessions in April, 2008.

The treating physician is, M.D. who has seen him regularly since the time of his surgery. There are multiple notes available for review from Dr. On May 19, 2008, Dr. indicated that the patient had not completed his Work Hardening Program because he was not able to pay for gas for transportation. He did have more pain in May, 2008 because of the amount of lifting and pushing he was doing. His acromioclavicular joint was injected at that time.

Notes from Dr. in 2009 include notes on January 5, 2009, April 20, 2009, July 13, 2009, and October 12, 2009. In his note of October 12, Dr. noted that the patient had started having a recurrence of right shoulder pain with tenderness, pain, and weakness. Apparently, these symptoms and physical findings were new and were alarming enough to prompt Dr. to order a MRI of the shoulder. The MRI showed evidence of subacromial subdeltoid bursitis and tendinosis of the supraspinatus and subscapularis tendons. Due to these findings on MRI, the increased pain and tenderness, and the weakness which the patient had developed in the fall of this year, Dr. felt he would require another course of physical therapy for treatment of this apparent exacerbation of his symptoms and physical findings. Dr. working diagnoses were rotator cuff syndrome and bicipital tenosynovitis. There is a request for physical therapy three times a week for four weeks.

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

He had extensive therapy following this including a work hardening program. He reportedly returned to work unrestricted. It would appear to be medically necessary that Mr. could receive treatment for this exacerbation or recurrence of symptoms and physical abnormalities. However, the time frames involved are too great. This PT is requested is greater than 10 weeks beyond the exacerbation.

Physical therapy three times a week for four weeks, however, exceeds that recommended by the ODG Guidelines. For a rotator cuff syndrome, 726.1, medical treatment for this disease entity would be ten treatments over eight weeks. For the bicipital tenosynovitis diagnosed by Dr., 726.12, the ODG Guidelines recommend six to eight visits over ten weeks. The denial of the requested therapy is based on the fact that the requested therapy exceeds therapy recommended by the ODG Guidelines.

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)**