

MEDR X

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Notice of Independent Review Decision

DATE OF REVIEW: 1/17/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The serviced under review includes the medical necessity of physical therapy 3 times per week for 4 weeks.

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

The reviewer is a licensed physical therapist who has been in active practice for greater than 5 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 medical necessity of physical therapy 3 times per week for 4 weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Mutual and PT.

These records consist of the following (duplicate records are only listed from one source): 12/30/09 letter, 11/25/09 denial letter, 12/17/09 denial letter, progress notes by MD from 7/2/08 to 4/15/09, 10/15/08 to 11/11/09 notes by MD, 10/14/08 operative report, 10/1/09 shoulder eval and 11 pg treatment history report.

Valeo PT: 12/29/09 letter by, 12/9/09 letter by PT, 12/19/09 note by MD, 11/17/09 shoulder evaluation and 11/11/09 PT script.

We did receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured worker is a female who injured her right shoulder at work. She was diagnosed with a labral tear. She had surgery on 10/14/08 and completed 12 post operative sessions in 2008. Valeo evaluated the patient on 11/17/09 and has requested the 12 additional sessions which have been denied by the carrier.

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

The reviewer notes that upon reviewing the clinical documentation and records provided there is a lack of clinical documentation regarding the post operative PT. Dr. note of 9/30/09 notes the patient doing well postoperatively until 6 weeks previous when she returned to the teller line. She was evaluated by Advantage PT on 10/1/09 with POC for six sessions over two weeks. No PT notes or discharge notes were provided to indicate how the patient responded to this treatment.

Dr. note of 11/11/09 shows the patient feels that the PT aggravated her symptoms. The note indicates he requested deep tissue massage for underlying MDI. This patient does not meet the ODG requirements for an extension of PT beyond 12 visits at this time.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)