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Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 06/08/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy three times a week for four weeks for the right shoulder

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

Board Certified in Orthopedic Surgery

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.

Physical therapy three times a week for four weeks for the right shoulder -
Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 12/13/06, 02/08/07, 02/28/07, 10/30/07, 11/06/07, and 01/18/08

An MRI of the cervical spine interpreted by, M.D. dated 10/31/07

An MRI of the right shoulder interpreted by Dr. dated 10/31/07

Medication prescriptions from, M.D. dated 02/01/08, 06/06/08, 06/30/08, 08/11/08, 11/12/08, 12/10/08, 01/14/09, 02/18/09, 04/08/09, and 02/15/10

Therapy prescriptions from Dr. dated 02/01/08, 06/06/08, 08/11/08, 09/08/08, 10/06/08, 11/05/08, 02/18/09, 01/04/10, 01/18/10, and 04/21/10
Evaluations with Dr. dated 02/01/08, 04/28/08, 06/06/08, 08/06/08, 08/07/08, 08/11/08, 09/08/08, 10/06/08, 11/05/08, 11/12/08, 12/10/08, 01/14/09, 02/18/09, 03/13/09, 03/20/09, 04/08/09, 04/17/09, 06/19/09, 09/28/09, 11/09/09, 11/25/09, 01/04/10, 01/18/10, 02/15/10, 02/24/10, 04/21/10, and 05/28/10
DWC-53 forms dated 03/06/08 and 04/28/08
DWC-73 forms from Dr. dated 06/30/08, 11/05/08, and 11/12/08
Precertification requests from Dr. dated 07/01/08 and 01/07/10
Notices of Denial, according to the Official Disability Guidelines (ODG), from, M.D. dated 07/03/08 and 04/28/10
Notices of Preauthorization from Dr. dated 07/07/08, 12/10/09, and 01/13/10
Evaluations with, O.T.R., C.H.T. dated 08/07/08 and 01/21/10
Attending physician statements from Dr. dated 10/06/08, 04/07/09, 04/14/09, 04/22/09, and 10/27/09
Physical therapy with Ms. dated 10/20/08, 10/27/08, 10/29/08, 10/31/08, 11/03/08, 11/10/08, 11/21/08, 11/24/08, 12/01/08, 01/26/10, 02/04/10, and 02/11/10
An evaluation with, M.D. dated 12/10/08
An impairment rating form from Dr. dated 02/18/09
A report from, P.T., M.H.S., C.H.T. dated 03/05/09
An impairment rating evaluation with Dr. dated 03/09/09
A prescription from Dr. dated 03/13/09
Electrodiagnostic study and imaging requests from Dr. dated 03/13/09 and 03/20/09
An EMG/NCV study interpreted by, M.D. dated 03/30/09
An MRI of the cervical spine interpreted by, M.D. dated 03/30/09
Evaluations with, M.D. dated 04/23/09, 06/23/09, 07/21/09, 08/06/09, 08/27/09, 09/15/09, 09/22/09, and 10/22/09
A Designated Doctor Evaluation with, M.D. dated 07/13/09
A discharge summary from Ms. dated 07/23/09
An EMG/NCV study interpreted by, M.D. dated 11/19/09
An MRI of the cervical spine interpreted by, M.D. dated 11/19/09
An MRA of the right upper extremity interpreted by, M.D. dated 12/22/09
An EMG/NCV study interpreted by, M.D. dated 04/06/10
A letter of medical necessity from Ms. dated 05/04/10
A Notice of Reconsideration, according to the ODG, from, D.O. dated 05/12/10
An undated attending physician statement from Dr.
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

An MRI of the right upper extremity interpreted by Dr. on 12/22/09 was unremarkable. On 01/04/10, Dr. noted the patient was almost five months post a right shoulder subacromial decompression and distal claviclectomy and four and a half months post C4, C5, and C6 surgery. An EMG/NCV study interpreted by Dr. on 04/06/10 showed mild carpal tunnel syndrome and possible distal brachial plexus stretch injury or pectoralis minor syndrome. On 04/21/10, Dr. recommended physical therapy. On 04/28/10, Dr. wrote a letter of denial for

physical therapy three times a week for four weeks. On 05/04/10, Ms. wrote a letter of medical necessity for physical therapy and a TENS unit. On 05/12/10, Dr. wrote a letter of denial 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.

The claimant's injury occurred on xx/xx/xx. The patient has had surgery for the shoulder and the cervical spine. There has been no recent surgery or re-injury that would indicate an acute need for therapy at this time. The physical therapy was requested by a physical therapist and the Letter of Medical Necessity was signed by a physical therapist, in which the physical therapist claims diagnoses such as thoracic outlet syndrome and brachial plexus compression. Although an EMG/NCV study was performed on 04/06/10, it was not confirmatory for thoracic outlet syndrome or brachial plexus compression. In fact, the last examination by a physician, Dr., stated that there was little orthopedic sequela of the injury at the time of his examination. Thus, the requested physical therapy three times a week for four weeks for the right shoulder is neither reasonable nor necessary and the previous adverse determinations should 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 AND KNOWLEDGE BASE
- 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)