

Wren Systems

An Independent Review Organization
3112 Windsor Road #A Suite 376
Austin, TX 78703
Phone: (512) 553-0533
Fax: (207) 470-1064
Email: manager@wrensystems.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/05/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 PT sessions 97110-97035-97140

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

MD, Board Certified in Physical Medicine and Rehabilitation

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Physical Therapy Guidelines
Denial Letters, 5/21/10, 6/10/10
Physicians 6/1/10, 4/7/10, 3/31/10
APEX 5/24/10, 5/17/10, 4/22/10, 4/14/10, 6/2/10

PATIENT CLINICAL HISTORY SUMMARY

This is a woman who fell on xx/xx/xx. She was diagnosed with a shoulder injury and knee injury. The shoulder was initially felt to be a strain/sprain, but the diagnosis was changed to a rotator cuff injury. She improved with better motion and less pain. She is at work with restrictions on lifting (Dr). She had 12 sessions of therapy and there is a request for 12 additional sessions for improved motion and reduced pain. She reportedly still has pain and a positive empty can test on the left side.

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

According to the ODG Physical Therapy Guidelines, all therapies are to be targeting a reduced intensity with reduction to once weekly with a home program. The patient was at three times weekly and the therapists want to continue this therapy three times weekly. Further, strains and rotator cuff injuries are each recommended for 8 sessions over 10 weeks. She has had 12 sessions in 4 weeks without the reduction in frequency noted. Both exceed the care recommended in the ODG. The requesting parties note that the goal is to improve motion and reduce pain. They did not explain why they had not followed the ODG

protocols or why they feel that the extra treatment beyond the ODG protocols would be needed. Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld. The reviewer finds that medical necessity does not exist for 12 PT sessions 97110-97035-97140.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)