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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 7/16/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of physical therapy three times per week for four weeks. (12 visits)

**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 performing this type of service for more 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 physical therapy three times per week for four weeks. (12 visits)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
xxxxxx.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Dr.: handwritten at the top of the request form indicating this is "not our patient".

: 6/17/10 denial letter, 6/25/10 denial letter, 6/14/10 preauth request, 5/28/10 order requisition form, UE evaluation of 6/11/10, 5/28/10 eval by Dr., PT additional information page and 6/17/10 reconsideration request.

xxxx: 6/30/10 letter by, Index of Documents, 4/1/10 IRO decision, various TWCC 21 forms, PLN11 form 4/14/10, 11/12/99 FCE report, 4/21/04 FCE report, 6/11/04 MRI report of left shoulder, 6/25/04 EMG report, 9/9/04 left wrist MRI report, 9/16/04 neurodiagnostic report, 12/1/04 PPE report, 6/18/07 FCE report, 6/29/07 FCE report, 6/29/07 DD report, 4/15/10 x-ray report, notes from xxxx from 7/31/06 to 5/28/10, handwritten notes 8/14/09 to 2/10/10, 10/20/09 report by MD, 4/14/10 notes by MD, 4/15/10 surgical note, 3/19/07 IR report, 10/20/09 RME report,

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured xxxx years ago while on the job due to xxx. Work up was consistent with mild CTS bilaterally and left subacromial bursitis. She has undergone management with analgesics, antidepressants, anticonvulsants, right shoulder injection, OT/PT, right CTR, and spinal cord stimulator implantation. An MRI on 12/4/09 revealed a partial cuff and labral tear at the right shoulder. An additional 6 visits of PT is requested by Dr. based on the note on xxxxx. On xxxxx, Dr. indicates that chronic pain management program was requested and denied.

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

ODG: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

ODG: Carpal tunnel syndrome (ICD9 354.0):

Medical treatment: 1-3 visits over 3-5 weeks

Post-surgical treatment (endoscopic): 3-8 visits over 3-5 weeks

Post-surgical treatment (open): 3-8 visits over 3-5 weeks

The documentation provided indicates that OT and PT have already been offered for this chronic condition. There is no documentation that indicates the exact number of visits already provided; however, the length of the condition would suggest that the maximum number of treatment sessions have been exceeded. Therefore, the requested service is not medically necessary.

**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)