INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 05/25/10

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute:
97110 Physical Therapy Cervical/Left Shoulder 3xwk x4wks
97140 Myofascial Release Cervical/Left Shoulder 3xwk x4wks
G0283 Electrical Stimulation Cervical/Left Shoulder 3xwk x4wks
97140 Joint Mobilization Cervical/Left Shoulder 3xwk x4wks

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an injury on xx/xx/xx.

The initial clinic evaluation on the date of injury indicated the symptoms began when the employee pulled a bag carousel, which felt heavier than usual, and felt a pop in her shoulder. The employee was diagnosed with a shoulder injury and paresthesias, and was recommended for nerve studies and was placed on Tramadol and Skelaxin.

From 02/16/10 to 02/26/10, the employee was seen at Chiropractic for six sessions, which included passive therapies only. On the last visit, the employee's visual analog score continued to be 10/10.

A left shoulder MRI on 02/24/10 revealed anomalies and spurring consistent with impingement, with acromioclavicular joint arthropathy, and subacromial bursitis.

On 03/09/10, the employee saw a neurologist for an evaluation, who recommended nerve conduction studies to rule out cervical radiculopathy.

On 03/23/10 to 04/22/10, the employee was seen at xxxxxx, whose notes indicated that the employee saw both a medical doctor and a chiropractor. The employee was diagnosed with cervical disc protrusion, cervical spine strain and sprain, shoulder strain and sprain, and neuralgia. The recommendation was for twelve visits of physical therapy to the cervical region and left shoulder, myofascial release to the cervical region and left shoulder, electrical stimulation to the cervical and left shoulder, and joint mobilization of the cervical and left shoulder.

An MRI on 05/11/10 revealed a 1.5 mm broad-based disc protrusion at C5-C6 with mild indentation of the ventral thecal sac and approach with contact of the ventral aspect of the cord. There was mild right neuroforaminal narrowing and mild central canal narrowing. There were central disc herniations at C2-C3 through C4-C5 without significant neuroforaminal or central canal narrowing.

Previous reviews found an adverse determination based upon failure of improvement with a prior six session trial, and that the mechanism of occupational injury was not supported with the diagnosis given.

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

Agreement is made with the previous reviews. There is indication that with the initial passive therapy the employee received, there was no improvement. Additionally, the request includes passive modalities, which are not supported in the guidelines. In

consideration of the records and the facts presented, there is little support of evidence to recommend the necessity of the 97110 Physical Therapy Cervical/Left Shoulder 3xwk x4wks, 97140 Myofascial Release Cervical/Left Shoulder 3xwk x4wks, G0283 Electrical Stimulation Cervical/Left Shoulder 3xwk x4wks, 97140 Joint Mobilization Cervical/Left Shoulder 3xwk x4wks

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

Official Disability Guidelines, Shoulder Chapter, Online Version
Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):
Medical treatment: 10 visits over 8 weeks

Official Disability Guidelines, Neck and Upper Back Chapter, Online Version
Sprains and strains of neck (ICD9 847.0):
10 visits over 8 weeks