



Notice of Independent Review Decision

DATE OF REVIEW: 10/26/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy 1 x 4

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

Board Certified in Physical Medicine & 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)

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 1 x 4 – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Consultation/Referral Request, 03/04/10, 07/07/10, 07/21/10
- Encounter Notes, M.D., 03/05/10, 03/12/10, 03/26/10, 04/21/10, 04/28/10, 05/05/10, 05/12/10, 05/19/10, 05/26/10, 06/02/10, 06/09/10, 06/16/10, 07/07/10, 07/21/10, 07/28/10, 08/11/10, 08/18/10, 08/25/10, 09/03/10, 09/15/10, 09/29/10, 10/06/10
- Physical Therapy Referral, 03/05/10, 05/05/10, 08/11/10, 08/20/10
- DWC Form 73, Dr., 03/05/10, 03/12/10, 03/26/10, 04/21/10, 04/28/10, 05/05/10, 05/12/10, 05/19/10, 05/26/10, 06/02/10, 06/09/10, 06/16/10, 07/07/10, 07/21/10, 07/28/10, 08/11/10, 08/18/10, 08/25/10, 09/03/10, 09/15/10, 09/29/10, 10/06/10
- Left Shoulder MRI, M.D., 04/26/10
- Authorization, 05/28/10
- Encounter Notes, M.D., 06/21/10
- DWC Form 73, Dr. 06/21/10
- Left Biceps Steroid Injection, M.D., 07/14/10
- Physical Therapy, Rehab, 07/14/10, 07/16/10, 07/20/10
- Evaluation, M.D., 08/02/10
- DWC Form 73, Dr. 08/02/10
- Pre-Authorization Request, Rehab, 08/13/10
- Denial Letter, 08/17/10, 08/30/10
- Referral Information, Undated
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The records available for review document that the date of injury was listed as xx/xx/xx. On the date of injury, the patient was employed as a xx. She was on a xx when one of the children got out of some restraints. The patient attempted to place the individual back into a seat and developed difficulty with left shoulder pain.

The patient received an evaluation with Dr.. It was documented that left shoulder x-rays were “unremarkable.” It was recommended that she receive access to treatment in the form of physical therapy.

Dr. re-evaluated the patient on 03/26/10 and 04/21/10. On those dates, there were no neurological deficits noted to be present upon physical examination.

A left shoulder MRI scan was accomplished on 04/26/10. The study revealed no findings worrisome for a rotator cuff tear. There was evidence for a mild amount of fluid in the subacromial/subdeltoid bursa.

Dr. re-evaluated the claimant on 04/28/10. On that date, the patient received an injection of Celestone and Marcaine to the left shoulder. On 05/05/10, Dr. evaluated the patient once again. It was recommended that she continue to receive access to treatment in the form of physical therapy. On 05/19/10, Dr. evaluated the patient. She was diagnosed

with a sprain as well as subacromial bursitis in the affected shoulder. It was recommended that she continue access to treatment in the form of physical therapy. Dr. re-evaluated the patient on 06/09/10. There were no focal neurological deficits noted on physical examination of the left upper extremity.

On 06/21/10 the patient was evaluated by Dr.. On that date, the claimant received a therapeutic injection to the left shoulder.

On 07/07/10, Dr. evaluated the patient. There were no neurological deficits noted to be present upon physical examination of the left shoulder. Dr. evaluated the patient again on 07/21/10. It was recommended that she receive an evaluation with Dr..

The patient was then evaluated by Dr. on 08/02/10. On that date there were no neurological deficits noted to be present upon physical examination of the left upper extremity.

On 08/11/10, Dr. re-evaluated the patient. It was noted there was tenderness to palpation over the anterior aspect of the left shoulder.

The records available for review indicate that by 08/17/10 the patient had received 21 sessions of physical therapy.

Dr. re-evaluated the claimant on 08/18/10 and 08/25/10. On those dates it was recommended that she receive access to treatment in the form of physical therapy services. The patient continued to treat with Dr. on 09/03/10, 09/15/10, 09/29/10, and 10/06/10. On those dates, there were no documented neurological deficits noted to be present on physical examination of the left upper extremity.

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

Based upon the medical records presently available for review, medical necessity for additional treatment in the form of physical therapy 1 x 4 would not appear to be indicated per criteria set forth by the Official Disability Guidelines. The primary medical condition would truly appear to be that of a muscular strain and/or contusion of the left shoulder. Such a medical condition is a medical condition which is typically considered to be self-limiting in nature. An MRI scan of the left shoulder accomplished after the date of injury was essentially unremarkable. For the described medical situation, Official Disability Guidelines would support an expectation that an individual should be capable of a proper non-supervised rehabilitation regimen for the described medical situation when an individual is this far removed from the onset of symptoms and when an individual has received access to the amount of supervised therapy services previously provided. Thus, based upon the medical records currently available for review, Official Disability Guidelines would not support a medical necessity for ongoing treatment in the form of supervised therapy services.

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)
- AMA GUIDES 5TH EDITION