

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: Apr/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of aquatic Physical Therapy to include 4 units of therapeutic exercises 1 unit of myofascial release 1 unit of interferential 1 unit of ultrasound and 1 unit of joint mobilization

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

MD, Board Certified in Physical Medicine and Rehabilitation
Board Certified in Pain Management
Board Certified in Electrodiagnostic Medicine

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

PATIENT CLINICAL HISTORY SUMMARY

This is a woman injured on xx/xx/xx. She had a prior labral repair in 2003. She reportedly had a C5/6 radiculopathy based upon EMG findings isolated to the left deltoid. Her MRI reported several cervical disc bulges and osteophytes. She underwent a discectomy and fusion on 4/16/08 for spinal stenosis and disc herniation. She was found to have an articular surface tear of the right supraspinatus with subacromial decompression repairs in 2008 and 2009. She had a subacromial injection by Dr. in 10/10. Another note said she had not had the 3 therapy sessions and a home program was not helping. Another note said she had some therapy in 2007. The 1/5/11 note stated that, "the patient has not had PT for over a year. The patient will require aquatic PT." This implies she had some prior therapy, another note in 2010 states that "PT is medically necessary three times a week for six weeks or 18 sessions.

The patient will undergo aquatic exercises..."

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

The ODG discusses aquatic therapy in the lumbar region, not in the cervical or shoulder sections. Aquatic therapy would be included with other physical therapy treatments. It is unclear from the records available for this review how much therapy the patient has had. Her injury is now more than x years old. The cervical fusion was 3 years ago and the shoulder surgery was 2 years ago. She had an injection in 10/10. The ODG clearly limits therapy as an option after a shoulder injection to 2 sessions at most. At this point, though, it would be too late to be of any benefit this far after the injection.

ODG would recommend physical therapy after an arthroscopic procedure of 24 sessions. This patient's surgery was more than 2 years ago, however. ODG would recommend 24 therapy sessions after a cervical fusion, but again, this patient's fusion was more than 5 years ago. The doctor's notes describe a frozen shoulder. This is chronic. In the records reviewed, there were no new or acute problems to warrant the therapies as requested. The reviewer finds there is no medical necessity at this time for 12 sessions of aquatic Physical Therapy to include 4 units of therapeutic exercises 1 unit of myofascial release 1 unit of interferential 1 unit of ultrasound and 1 unit of joint mobilization.

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)