

# Parker Healthcare Management Organization, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** AUGUST 8, 2011

**IRO CASE #:**

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

Medical necessity of proposed physical therapy and aquatic therapy (97010, 97035, 97110, 97113, 97140, 97530) 2-3 X week X 4 weeks (8-12 Sessions)

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

This case was reviewed by a Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of 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)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
847.0/ 722.0	97010		Prosp	8-12					UPHELD
847.0/ 722.0	97035		Prosp	8-12					UPHELD
847.0/ 722.0	97110		Prosp	8-12					UPHELD
847.0/ 722.0	97113		Prosp	8-12					UPHELD
847.0/ 722.0	97140		Prosp	8-12					UPHELD
847.0/ 722.0	97530		Prosp	8-12					UPHELD

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

TDI-HWCN-Request for an IRO-14 pages

Respondent records- a total of 20 pages of records received to include but not limited to: TDI letter 7.18.11; IMO letters 6.29.11, 7.8.11; IMO Preauthorization request; Orthopaedic Surgery Group records 6.10.11-6.21.11; email to from dated 6.30.11

Requestor records- a total of 27 pages of records received to include but not limited to: PHMO Notice of an IRO; DWC form 73, dated 4.27.11, 5.26.11, 6.3.11,7.7.11; Orthopaedic Surgery Group records 4.27.11- 7.7.11 ; MRI Rt Shoulder 5.10.11; MRI Rt Scapula 5.10.11; NEXUS report 5.18.11; report, M.D. dated 5.26.11; MRI Cervical spine 7.1.11

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

The medical records presented for review begin with the July 7, 2011 clinical evaluation completed by Dr.. The presenting complaint was neck pain. The physical examination noted decreased range of motion, spasms and tenderness. MRI noted spondylitic changes at multiple levels, spinal stenosis and a disc lesion at C3-4. There is a reported EMG that was "suggestive" of a radiculopathy. A TENs unit was prescribed. The medical protocol was modified.

A right shoulder MRI was obtained on May 5, 2011 and noted a rotator cuff tear and biceps tendon injury. Arthrosis of the acromial-clavicular joint is reported as well.

Dr. completed a peer review and opined that the overuse syndrome and myofascial strain of the neck is not a function of the reported mechanism of injury. Dr. endorsed the initial sessions of physical therapy.

Dr. completed the EMG and reported a carpal tunnel syndrome with a chronic radiculitis; but could not determine the location as there were no findings in the arm to isolate the location of the offending lesion.

In June 2011, the request for heat/cold therapy, ultrasound, therapeutic exercise, aquatic therapy with therapeutic exercise, manual therapy and therapeutic activities was "not authorized". It was noted that 8 sessions of physical therapy had been completed. It was felt that some home based protocols should have been employed and there is no data presented of any improvement with this initial protocol.

The June 21, 2011 physical therapy evaluation from PT notes that a 30 day trial of physical therapy had been completed. Shoulder range of motion is reported to be full. An additional 12 sessions (2-3 times a week for four weeks) was sought.

A re-consideration of the additional physical therapy was also not certified. There is some question as to the extent of injury.

## **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.**

**RATIONALE:**

As noted in the Division mandated Official Disability Guidelines, physical therapy for the non-surgically treated shoulder would be 10 visits over 8 weeks.

Sprained shoulder; rotator cuff (ICD9 840; 840.4):  
Medical treatment: 10 visits over 8 weeks

The same is true for the cervical myofascial strain. The last physical therapy physical examination noted a full range of motion and some weakness with no discussion of why a home based strengthening program could not be implemented. There is no clear discussion of the efficacy of the cervical therapy protocol. Therefore, when noting the type of injury sustained, the reported mechanism of injury, the physical therapy physical examination and the amount of physical therapy already completed, there is no clear clinical indication for the additional therapeutic visits requested.

**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
- XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- XX 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)