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: Aug/12/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical therapy 3 times per week for 4 weeks right shoulder

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Adverse Determination Letters, 06/09/11, 06/22/11
Clinical records Dr. 06/03/11 through 06/22/11
Official Disability Guidelines, Shoulder, Physical Therapy

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female who is reported to have sustained work related injuries on xx/xx/xx. On 06/03/11 the claimant was seen by Dr.. The claimant is reported to have slipped on spilled coffee landing on her right side hitting her right knee hip and shoulder. Initially she was reported to have sustained contusions to her neck and then the back of her head. There was no loss of consciousness. She subsequently initiated treatment with her family doctor. She is employed as a barista at Starbuck's. She presents with complaints of shooting pain and stiffness in the neck that causes headache. She has radiating pain to the shoulder blades. She has constant neck pain. She has spasms that come and go. She has back pain that is improving. She has improvement in her right hip pain. She has radiation of the lower back into the legs. Her neck is reported to be stiff. She goes to a pool and exercises. Current medications include Norco 10 325 four times per day Robaxin 750mg Trazadone 150mg Effexor 75mg and Neurontin 800mg PO TID. She has past surgical history that includes right carpal tunnel release, left shoulder surgery in 2000, and right elbow surgery. She has previously received physical therapy for the neck and back, reported to be four to six sessions and six sessions for the right hip and a right hip injection. She has undergone EMG of the upper and lower extremities. The lower extremities are reported to be normal. Upper extremities performed on 05/09/10 are reported to show bilateral median neuropathy. MRI of the lumbar spine dated 05/04/09 shows a grade 1 spondylisthesis of L4 and L5 causing moderate central canal stenosis. There is a 4-5mm broad based disc protrusion at L3-4 and a disc spur that extends into the neural foramina with possible compromise of the L3 nerve root. A right hip arthrogram was performed on 01/08/10. This showed evidence of labral

tearing on the anterior labrum and a right greater trochanteric bursitis. MRI of the pelvis dated 05/29/09 showed a partial high-grade tear of the right quadratus femoris and partial tearing of the hamstring tendon origin. MRI of the cervical spine dated 05/04/09 shows severe canal stenosis at C4-5 related to a 4-5mm disc extrusion, mild cord compression, moderate to severe bilateral neural foraminal narrowing. There is moderate canal narrowing at C5-6 related to a 3-4mm disc protrusion. She is 5'4" tall and weighs 252 pounds. She has a normal gait. She is able to stand on her heels and toes. She has mild to moderate cervical tenderness reduced cervical range of motion. She has severe tenderness of the dorsal lower third of the forearm. She has mild to moderate tenderness of the anterior shoulder. Forward flexion is to 100 degrees, abduction is to 100 degrees.

Hawkins and Neer's impingement tests are positive. She has reduced lumbar range of motion. Straight leg raise is reported to be positive on the right. She has positive sciatic notch tenderness. Patrick's test is positive on the right. She has moderate tenderness of the medial and lateral joint line of the right knee with full range of motion. Motor strength is graded as 5/5 sensation is intact reflexes are 2+ and symmetric. She subsequently is diagnosed with lumbar disc disorder, right shoulder sprain, hip sprain, partial tear of the right upper quadriceps and right hamstring cervical disc disorder, cervical radiculitis and L4-5 radiculitis. She subsequently was recommended to see Dr., a neurologist, and orthopedic consult with Dr.. She is status post LESI facet injection on 02/23/11 and a rhizotomy on 04/13/11. She has been recommended for bilateral SI joint injections. She was evaluated by physical therapy on 05/23/11 who recommended three times four. She was recommended to have trigger point injections and she was to be seen by Dr. on 02/14/11 for arthroscopic hip surgery. On 06/09/11 the initial request was reviewed by Dr., who noted that the claimant is already well past the acute stage of injury, and formal physical therapy at this point may not provide significant added functional benefit as compared to a daily home exercise program. He denied the request for Physical therapy 3 times per week for 4 weeks right shoulder. On 06/14/11 Dr. submitted a letter of appeal noting that this was a chronic case and the claimant has not had any physical therapy treatments to date for the right shoulder for this particular injury or case. The reported left shoulder surgery occurred over 10 years ago and is not related to this injury. He notes that the passage of times simply does not result in resolution of pain or restoration of function. He recommends a trial of physical therapy and opines that a trial of physical therapy should be allowed to determine if objective improvements can be achieved. He subsequently requests 12 occupational therapy visits with all active modalities to be done concurrently with a home exercise program. The subsequent appeal review was performed by Dr. who notes that there is no documentation of the nature and extent of post-surgical functional recovery and if current findings represent a decline in active range of motion whether the range of motion measurements cited are active or passive. There is no documentation of any functional deficits experienced by the worker relative to the right shoulder. He notes the date of right shoulder surgery is not reported and at this time it is presumed that this is a post work related injury procedure for which appropriate post-operative physical rehabilitation would have been directed by the surgeon physiatrist or other physician. He opines that the current request for 12 sessions cannot be established as medically necessary. Dr. responded that x-rays of the right shoulder were normal and MRI of the shoulder has not been requested since the claimant has not completed a trial of physical therapy and therefore an MRI could not be ordered.

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

The submitted clinical records do not provide detailed information. It is noted that the claimant has a xxxx date of injury. The claimant first came under the care of Dr. on 09/14/10. Clearly the claimant has had treatment in the interval period from the date of injury through her initial evaluation by Dr. on 09/14/10. These clinical records are germane to whether or not additional physical therapy is warranted and with regard to the nature and type of physical therapy that the claimant has received in the past. It is highly unlikely that the claimant had not received treatment for this condition prior to her initial visit with Dr. on 09/14/10. It would further be noted that Dr. clinical records do not provide supporting documentation regarding previous treatments. There are no physical therapy records from which to establish the

efficacy of this treatment for the claimant. Based upon the submitted clinical information the requested Physical therapy 3 times per week for 4 weeks right shoulder is not supported by the available data and therefore the previous utilization review denials are upheld. The reviewer finds there is not a medical necessity at this time for Physical therapy 3 times per week for 4 weeks right shoulder.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)