

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 05/05/11

**IRO CASE NO.:**

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

Item in dispute: 97110 Therapeutic Exercise reconsideration for 9 Sessions (3 times a week for 3 weeks) Physical Therapy – Right Knee, Left Shoulder, Elbow and Wrist as not medically necessary.

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

Texas Licensed Chiropractor

**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**

1. 02/25/11 - Clinical Note -, D.C.
2. 03/04/11 - Clinical Note -, M.D.
3. 03/15/11 - Clinical Note -, D.C.
4. 03/17/11 - MRI Left Wrist
5. 03/17/11 - MRI Right Knee
6. 03/17/11 - MRI Left Shoulder
7. 03/30/11 - Clinical Note -, D.C.
8. 04/07/11 - Adverse Determination Letter
9. 04/14/11 - Clinical Note -, M.D.
10. 04/20/11 - Notice of Assignment of Independent Review Organization
11. ***Official Disability Guidelines***

**PATIENT CLINICAL HISTORY (SUMMARY):**

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

The employee saw Dr. on 02/25/11 with complaints of pain to the left ankle, left arm, right knee, and right hip rating 5 to 6 out of 10. The employee reported sleep disturbance due to pain. Physical examination of the left shoulder revealed inflammation and tenderness at the anterior, posterior, and medial portion. Range of motion was restricted. Abduction was to 30 degrees, adduction is to 20 degrees, flexion

was to 75 degrees, and extension was to 35 degrees. Hawkin's test was positive. Drop arm test was positive. Range of motion of the left elbow revealed flexion to 130 degrees and extension to -10 degrees. There was gradual development of paresthesia in the small finger and ring finger. Examination of the left wrist revealed swelling. There was tenderness to palpation at the anterior, posterior, and lateral portion. The triangular fibrocartilage complex compression test was positive. There was decreased sensation in the hand at C6 and C7. The employee was assessed with shoulder sprain, elbow sprain, wrist sprain, and knee sprain. The employee was recommended for electrodiagnostic studies and an MRI of the cervical spine, knee, lumbar spine, shoulder and wrist. The employee was also recommended for nine sessions of physical therapy.

The employee saw Dr. on 03/04/11. The clinical note was difficult to interpret due to poor handwriting and copy quality. The employee complained of pain rating 5 to 6 out of 10. Physical examination revealed left shoulder flexion to 75 degrees, extension to 35 degrees, abduction to 30 degrees, and adduction to 20 degrees. Left elbow flexion was to 130 degrees and extension was to -10 degrees. The employee was prescribed Celebrex and Tramadol.

An MRI of the left wrist performed on 03/17/11 demonstrated a small amount of fluid in the intercarpal joint spaces. There was loculated cystic fluid collection in the volar aspect of the distal forearm deep to the flexor tendons, felt to represent a large ganglion cyst. There was bone marrow contusion or edema in the distal scaphoid bone. There was a tear of the ulnar attachment of the triangular fibrocartilage complex with small amount of fluid in the distal radioulnar joint space. An MRI of the right knee performed 03/17/11 demonstrated tricompartmental osteoarthritic change with patellofemoral chondromalacia. There were meniscal tears involving the posterior horn of the medial meniscus with extension into the body and superior surface. There was a tear of the posterior horn of the lateral meniscus with extension into the inferior surface. The cruciate and collateral ligaments were intact. There were no bone marrow signal abnormalities. An MRI of the left shoulder performed 03/17/11 demonstrated supraspinatus and infraspinatus tendinosis. There was a partial thickness bursal surface tear of the supraspinatus tendon. There was subdeltoid and subacromial bursitis. There was thinning of the glenoid labrum without definite tear. There was a small subchondral cyst in the greater tuberosity of the humerus.

The employee saw Dr. on 03/30/11 with continued pain complaints rating 6 out of 10. Physical examination of the left shoulder revealed inflammation and tenderness at the anterior, posterior, and medial portion. Range of motion revealed extension to 35 degrees, flexion to 75 degrees, abduction to 34 degrees, and adduction to 22 degrees. Hawkins's was positive. Drop arm test was positive. There was crepitus, tenderness, and swelling to the lateral portion of the lateral epicondyle. Range of motion of the left elbow revealed flexion to 130 degrees and extension to -10 degrees. There was gradual development of paresthesia in the small finger and ring finger. Examination of the wrist revealed crepitus, inflammation, and tenderness at the anterior, posterior, and lateral portion. Range of motion of the wrist revealed extension to 40 degrees, flexion to 25 degrees, radial deviation to 20 degrees, and ulnar deviation to 25 degrees. The employee was assessed with elbow sprain, wrist sprain, meniscal tear, and shoulder joint derangement. The employee was recommended for nine sessions of physical therapy.

The request for therapeutic exercises was denied by utilization review on 04/07/11. There was no indication of the number of physical therapy visits given to date. There was no evidence of objective functional improvements from the physical

therapy provided to date. The current request exceeded a trial of care of physical therapy without evidence of objective functional improvement from the treatment given to date. There was insufficient information provided to support the current request at that time.

The employee saw Dr. on 04/14/11 with continued pain complaints. Physical examination was unchanged. The employee was prescribed Nexium and Celebrex.

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

The clinical documentation provided for review does not support the requested physical therapy modality. The employee was referred for physical therapy; however, the employee's response to any physical therapy was not documented. There were no physical therapy summary reports or progress notes that identify the employee response or progress. The amount of physical therapy provided to the employee cannot be determined at this time. Additionally, there was no indication from the clinical notes what the employee's current physical therapy goals would be and no rationale regarding the functional benefits expected from physical therapy was given.

As the clinical documentation does not support additional physical therapy at this time, medical necessity is not established.

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

*Official Disability Guidelines*, Online Version, Forearm Wrist & Hand and Elbow Chapters  
ODG Physical Therapy Guidelines –

General: Up to 3 visits contingent on objective improvement documented (ie. VAS improvement of greater than 4). Further trial visits with fading frequency up to 6 contingent on further objectification of longterm resolution of symptoms, plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

Sprains and strains of elbow and forearm (ICD9 841):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks

Lateral epicondylitis/Tennis elbow (ICD9 726.32):

Medical treatment: 8 visits over 5 weeks

Post-surgical treatment: 12 visits over 12 weeks

Medial epicondylitis/Golfers' elbow (ICD9 726.31):

Medical treatment: 8 visits over 5 weeks

Post-surgical treatment: 12 visits over 12 weeks

ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

Sprains and strains of wrist and hand (ICD9 842):

9 visits over 8 weeks

Sprains and strains of elbow and forearm (ICD9 841):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment/ligament repair: 24 visits over 16 weeks