MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: November 14, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational Therapy Right Shoulder 3 x wk x 4 wks (97110).
Manual Therapy Right Shoulder 3 x wk x 4 wks (97140).

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

M.D., Board Certified in 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)

The requested service, Occupational Therapy Right Shoulder 3 x wk x4 wks (97110), is not medically necessary for treatment of the patient's medical condition.
The requested service, Manual Therapy Right Shoulder 3 x wk x 4 wks (97140), is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

A female patient's provider has requested authorization for Occupational Therapy (97110) and Manual Therapy (97140) of the right shoulder, each at a frequency of 3 sessions per week for 4 weeks. A review of the records indicates that the patient injured her right shoulder on xx/xx/xx while lifting an air conditioner at work. The patient initially presented on 7/11/11 with complaints of right shoulder and thoracic discomfort. On 7/18/11 the patient presented with continued pain and discomfort in her right shoulder region. On examination, the provider noted that the patient's sensation was intact, the Spurling maneuver was negative, and that there was paravertebral tenderness in the thoracic region and in the right upper trapezius. The shoulder forward flexion abduction was noted to be at 10 degrees. Physical therapy was recommended. On 7/19/11 the patient was noted to have a positive Neer impingement sign and positive Hawkins test and tenderness in the rhomboid of her right shoulder. The patient underwent an injection with 2 cc of dexamethasone and 8cc of Marcaine into her right shoulder. The patient reported 100% relief of her pain following the injection. On 8/2/11 the patient reported continued pain and loss of range of motion in her right shoulder. The provider indicated a diagnosis of a right shoulder rotator cuff tear and recommended a MRI and physical therapy. The patient reportedly attended physical therapy from 8/10/11 through 9/2/11. The patient underwent a MRI of her right shoulder on 9/9/11, which evidenced supraspinatus-infraspinatus junction tendinopathy and a glenohumeral joint effusion. On 9/12/11 the patient underwent an injection,

with 3cc of lidocaine and 1 cc of Kenalog, to her right shoulder. The provider has requested authorization for occupational therapy of the right shoulder (97110) and manual therapy (97140) of the right shoulder, each at a frequency of 3 sessions per week for 4 weeks. The Carrier indicates that a reasonable course of therapy has been authorized for the patient and she should be educated in a home exercise program. The Carrier additionally states that there is no clear rational as to why additional monitored therapy in excess of Official Disability Guidelines (ODG) recommendations would be medically necessary.

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

The Official Disability Guidelines (ODG) allow for physical medicine treatment (including physical therapy, occupational therapy and chiropractic care) for shoulder injuries. Per ODG, therapy for a non-surgical patient for a rotator cuff syndrome should consist of 10 visits over 8 weeks and also include training for a home therapy program. The patient was approved for 12 sessions of physical therapy approved. There are discrepant statements in the records provided regarding the actual number of physical therapy sessions attended by the patient; however, it appears that the actual number of sessions attended were less than 12. The number of sessions that were authorized for this patient was appropriate. There is no supporting documentation demonstrating the need or medical necessity for additional physical medicine treatment sessions. Therefore, the requested Occupational Therapy Right Shoulder 3 x wk x 4 wks (97110) is not medically necessary for this patient. Likewise, the requested Manual Therapy Right Shoulder 3 x wk x 4 wks (97140) is not medically necessary for this patient.

In sum, I have determined the following:
The requested service, Occupational Therapy Right Shoulder 3 x wk x4 wks (97110), is not medically necessary for treatment of the patient's medical condition.
The requested service, Manual Therapy Right Shoulder 3 x wk x 4 wks (97140), is not medically necessary for treatment of the patient's medical condition.

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

[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)