

Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: DECEMBER 29, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed physical therapy 3 X week X 6 weeks for right shoulder (97016, 97112, 97110, 97032)

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
840.4	97016		Prosp	18					Upheld
840.4	97112		Prosp	18					Upheld
840.4	97110		Prosp	18					Upheld
840.4	97032		Prosp	18					Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records presented for review begin with a letter of non-certification for the requested physical therapy services. Dr. noted that there were 18 pages of medical records to include an

MRI study noting a partial intrasubstance tear of the supraspinatus, bone marrow edema and degenerative joint changes of the acromial-clavicular joint. There was a decreased range of motion and marked complaints of pain. A rotator cuff tear repair had been completed on September 1, 2011, and post-operatively there had been 17 sessions of physical therapy.

The request was for passive modalities when the indications are for more active measures, this led to the non-certification.

An appeal of this determination was filed. This also was not certified secondary to the reported excessive nature of the request and the overall condition noted.

After completing 12 session of physical therapy, Dr. reported a functional range of motion to flexion (145°) and other examiners noted flexion to 170°. Sensory and motor were intact. Additional 6–18 visits of physical therapy were prescribed to increase strengthening.

On November 11, 2011, Mr. outlined the physical therapy that had been completed, 18 visits, and that there was a restriction ordered by the prescribing physician. Additional strength therapy was suggested.

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 is recommended for the post-operative shoulder, up to 24 visits over a 14 week period is outlined. The request from the Treating Doctor was for an additional three visits per week over a six week period, and based on the citations from the Official Disability Guidelines, the request as stated exceeds the ODG guidelines. Therefore, it is not deemed medically necessary.

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

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES