



MedHealth Review, Inc.

661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES:7/9/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 3 x wk x 4 weeks to the left shoulder (97110, 97124, 97535, 97035, G0283).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3 x wk x 4 weeks to the left shoulder (97110, 97124, 97535, 97035, G0283).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and Dr..

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 6/19/12 denial letter, 5/9/12 denial letter, 5/15/12 letter of reconsideration, office notes dated 1/4/11 PA-C, 10/22/10 left shoulder MRI report, 4/26/12 notes from Dr., and 2/11/12 and 5/3/12 progress reports by PM&R.

Dr.: office notes from Dr. 9/27/10 to 4/26/12, various DWC 73 forms, 9/20/10 to 4/26/12 scripts for Physical Medicine from Dr. medication scripts dated 10/22/10 to 10/12/11, DWC 69 and report by Dr. dated 6/17/11, and 11/1/10 and 2/11/11

progress reports by PM&R, daily handwritten office notes from PM&R 9/20/10 to 5/4/12, extremity testing report 9/22/10 to 2/11/11, 9/22/10 comprehensive evaluation by PM&R, 10/22/10 informed consent, patient's bill of rights 10/22/10, ROI form 10/22/10, Medical Center radiology reports 9/14/10, 9/14/10 Lortab script, Aftercare instructions undated, ER Records from Health System 9/14/10, and patient face sheet from Health Systems.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant has a date of birth of xx/x/xx. He reported that he was struck by a rear view mirror of a moving vehicle as he walked alongside a road on xx/xx/xx. He complained of pain to the left shoulder and left elbow. His diagnosis was a sprain of the left supraspinatus tendon/tear and sprain of left elbow and rotator cuff syndrome. He did have 18 visits of PT. He notes indicate that throughout the therapy from xx/xx to December 2010 he was at times in therapy and working, out of therapy and working, not working and going to therapy and not working and not going to therapy. On 11/12/2010 his pain was 1/10 and on 12/3/2010 his pain was 2/10. On 6/17/2011 he was not working and had no pain in the left elbow and some pain in the left shoulder. He was assessed and given a 0% impairment rating. On 12//2010 the shoulder and elbow range of motion was within normal limits. There is a note on 2/10/2011 that he attempted to restrain someone aggravating his shoulder and elbow. There is not a work injury report. On 2/11/2011 there was decreased range of motion of the shoulder and elbow. He was given a home exercise program.

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

This claimant has had 18 visits of PT for his injury. The ODG allows for fading treatment frequency from up to 3 visits per week to 1, plus active self-directed home PT. For a sprained shoulder, rotator cuff, 10 visits over 8 weeks are recommended. For a rotator cuff syndrome/impingement 10 visits over 8 weeks are recommended. There should be an increased in the active therapy as the therapy proceeds and decreased in passive care. There should be fading treatment frequency. Only passive care is not recommended. Home programs should be initiated with the first therapy sessions. Patients should be assessed after six visit clinical trial to see if they are moving in correct direction. When treatment duration and /or number of visits exceed the guidelines, exceptional factors should be noted. Throughout his therapy, his pain level has been variable. He had normal range of motion on 12/6/2010. He was seen on 5/3/2012 and again had "strong" pain. There was limited range of motion of the left shoulder and moderate pain in the left elbow. His progress has not been linear – with a complete recovery noted 6/17/2011 with 0% IR. He has been given a home exercise program. ODG recommends that a home exercise program be initially given. This patient has had 18 visits of PT and the need for

continued supervision for therapy is not supported by documentation. He is able to perform home exercises. There is no exceptional factor to warrant additional treatment. (ODG guidelines; physical therapy guidelines)

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
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- 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)