

I-Decisions Inc.

An Independent Review Organization
5501 A Balcones Drive #264
Austin, TX 78731
Phone: (512) 394-8504
Fax: (207) 470-1032
Email: manager@i-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

Signed electronically on: Sep/26/2012

DATE NOTICE SENT TO ALL PARTIES: Sep/26/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

outpatient physical therapy (PT) times eight (8) sessions (one to two (1-2) times a week for thirty (30) days) to the right upper extremity (RUE) consisting of therapeutic exercises, manual therapy neuromuscular re-education and not to exceed four (4) units per session

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

M.D., Board Certified Physical Medicine and Rehabilitation

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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute. The reviewer finds there is no medical necessity for outpatient physical therapy (PT) times eight (8) sessions (one to two (1-2) times a week for thirty (30) days) to the right upper extremity (RUE) consisting of therapeutic exercises, manual therapy neuromuscular re-education and not to exceed four (4) units per session.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female injured when she noticed continuous increasing pain from right hand / wrist, elbow/forearm and shoulder since moving to new work station. Her date of injury is noted to be xxxx. Ergonomic adjustments were made to her work station, and she began operating her mouse with left hand. Her symptoms gradually improved in her wrist, forearm, and elbow, but her upper arm and shoulder continue to be sore but manageable. She reported having increasing pain in upper arm and shoulder. The medical records indicate that she was treated conservatively with chiropractic, E-Stim and physical therapy. MRI of the right shoulder revealed partial tear of long biceps tendon, but superior labrum appears grossly intact. There is tear in the anterior superior labrum with fluid extending into the subcoracoid and subscapularis recess. Focal marrow contusion was noted through anterior humeral head adjacent to insertion of subscapularis tendon with small tear of superior margin of tendon adjacent to its insertion. A moderate grade sprain of anterior inferior glenohumeral ligament was noted.

Focal contusion of posterior lateral anatomical neck possibly representing some degree of posterior impingement was also noted. PT notes from 06/11/12 through 07/20/12 documented 8 sessions of physical therapy, and a request for 8 additional sessions of

physical therapy for right upper extremity was submitted for review. The request was denied as it was inconsistent with and exceeds ODG guidelines for submitted diagnoses, and there are no documented exceptional factors to warrant treatment above and beyond recommended ODG guidelines.

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

The claimant is noted to have sustained a repetitive motion injury due to typing and using a mouse when she changed work stations. She experienced increased pain to her right upper extremity. Her condition was refractory to conservative treatment including chiropractic treatment, E-stim, and physical therapy. According to the records, she has completed 15 visits of physical therapy. Per ODG guidelines, up to 10 visits over 4 weeks is supported for diagnosis of sprained shoulder and for sprain/strain of neck. The request for 8 additional physical therapy sessions on top of previously completed therapy exceeds Official Disability Guidelines. As noted on previous reviews there is no evidence of exceptional factors that would support the need for additional therapy in excess of guideline recommendations. The reviewer finds there is no medical necessity for outpatient physical therapy (PT) times eight (8) sessions (one to two (1-2) times a week for thirty (30) days) to the right upper extremity (RUE) consisting of therapeutic exercises, manual therapy neuromuscular re-education and not to exceed four (4) units per session.

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

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)