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Notice of Independent Review Decision

September 8, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 2xWk x 6Wks Left Upper Extremity (RSD)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The Reviewer is Board Certified in the area of Physical Medicine and Rehabilitation with over 16 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a female who injured her left arm due to a motor vehicle accident on xx/xx/xx. She was diagnosed with reflex sympathetic dystrophy.

05/14/2014: Plan of care. **Assessment/Recommendations:** Reflex Sympathetic Dystrophy, Chronic Pain Syndrome. She has attended 16 sessions of physical therapy and made good progress over the last 4 weeks with improved DASH score, improved pain, improved strength. Patient is compliant with HEP and compression glove use. She notes improved swelling, pain, and temperature with the glove.

05/28/2014: Clinical Note. **Physical Exam/Musculoskeletal:** Abnormal-Decreased abduction left shoulder, decreased flexion of the left shoulder, left should tenderness on palpation, pain to flexion of the left shoulder, pain to

abduction of the left shoulder. Decreased extension of the left elbow, ROM decreased in finger, visibly there is no deformity of the left UE when compared to the right, nor any gross muscular atrophy. She cannot fully extend at her right elbow and fingers due to pain. Spasm of left trapezius noted. Since February 2014, she has completed 16 sessions of physical therapy. **Current Medications:** Advair, baclofen, Lyrica, Norco, ProAir.

06/11/2014: Clinical Note. **Physical Exam/**M**usculoskeletal:** Spine is non TTP. Arm is TTP from shoulder down to hand, worse distally, can almost fully extend all fingers. Limited ROM in wrist. Patient stated her arm/hand is a lot better today, she was in contracture of hand/wrist and a lot of swelling in the beginning.

06/18/2014: Clinical Note. **Left shoulder**: no joint deformity, heat, swelling, erythema or effusion. Full range of motion. **Left Elbow:** no joint deformity, heat, swelling, erythema or effusion. Full range of motion. Patient unable to close hand over my first to demonstrate turning a doorknob to open a door. Severe pain elicited on placing 2 of my fingers in her left palm in an attempt to demonstrate ability of her fingers to make a fist- could not do it. **ROM:** Left Wrist: Limited active ROM. Left Wrist Passive: decreased passive ROM spasm.
Laxity/Stability: stable, contracture: lack full extension, lack full flexion.
Assessment: From the patient's report of function in the past, she is now able to move her left shoulder and elbow with physical therapy and medication.
Medications: Advair, ProAir, Norco 5mg, lidocaine, amitriptyline, Lyrica, baclofen.

06/23/2014: UR. Rational for Denial: The patient injured worker is a female who reported an injury on xx/xx/xx. The patient reported decreased grip strength and significant pain complaints in the right upper extremity and hand. Physical findings included limited range of motion of the left wrist, tenderness to palpation over the entire left forearm and wrist, and hypersensitivity of the left upper extremity with decreased fine motor strength secondary to pain. Official Disability Guidelines recommend up to 26 visits of physical therapy for reflex sympathetic dystrophy. The clinical documentation submitted for review does not clearly identify the number of visit the patient has already participated in. There is no way to determine the appropriate number of additional visits for this patient. Also, the clinical documentation does not provide clear indications that the patient has significantly benefitted from previous therapy. Therefore, continued physical therapy would not be supported. As such, the requested physical therapy 2 times per week for 6 weeks for the left upper extremity for reflex sympathetic dystrophy is non-certified.

07/02/2014: Appeal letter. had gone from being unable to move her left upper extremity to being able to move her left shoulder and elbow with physical therapy. Currently, she is still unable to grasp a door knob or hold an object in her hand, and attempting to do so causes her great pain. Clearly, there is still room for medical improvement, which in the past has occurred with medical management and aggressive physical therapy. is not yet at maximal medical improvement.

Without physical therapy, her current ability to use her left upper extremity will regress.

07/18/2014: Appeal letter. Please be advised we represent with regard to the collision she was involved in on xx/xx/xx. We are in receipt of your determination letter dated June 23, 2014, which included a report stating the denial of coverage for continued physical therapy. Please accept this letter as appeal of this determination and request for an expedited reconsideration of the determination. The determination letter listed he physician requesting physical therapy. However, has never been seen or treated. Upon investigation, retired from practicing medicine and thus, could not have been the requesting doctor. However, has been seen. and we have enclosed a letter dated July 2, 2014. As you will note, a physician who has examined and treated notes the need for continued physical therapy. In addition, date of birth is incorrectly listed. Lastly, medication for her injuries are not listed in there entirely. In addition to the medication listed in the letter, also takes Antiripylm 1/25mg, Lyrica 3/15mg, Baclofen 3/10mg and is prescribed a Lidocaine patch for use as needed. Accordingly, we request the determination be reversed and be granted coverage for continuing physical therapy.

07/22/2014: Clinical Note. **Physical Exam: Musculoskeletal:** Left upper extremity with pain on movement, supination and pronation of wrist and forearm is extremely painful for patient, and can only weakly grip her left hand over my fist. 4/5 muscle strength in left upper extremity compared to right upper extremity (5/5). **Assessment Plan:** Still awaiting or approval for neurology, physical therapy and pain management. Take medication as directed. Follow up with neurologist as soon as scheduled.

07/22/2014: Appeal letter. had gone from being unable to move her left and elbow with 17 visits with physical therapy. Currently, she is still unable to grasp a door knob or hold an object in her hand, and attempting to do so causes her great pain. Clearly, there is still room for medical improvement, which in the past has occurred with medical management and aggressive physical therapy. is not yet at maximal medical improvement. Without physical therapy, her current ability to use her left upper extremity will regress.

08/12/2014: Reconsideration of determination letter. I received your Notification of Adverse Determination for my client. As you know, was severely injured in a motor vehicle collision on xx/xx/xx. Since that time, she has been diagnosed with RSD in her left wrist and hand. The notification provided denies the reasonable and necessary treatment she needs for her condition. states in his review that “the number of completed PT visits was not documented and clear indications that the patient significantly benefitted from previous PT were not provided.” He further states that there was not information regarding the ROM or strength testing. Because finding are not supported by the medical evidence, we appeal the adverse determinations. First, we have enclosed documentation which apparently was provided showing limited range of motion in her hand and wrist (see medical visits of 6/11/14, 6/18/04, 7/22/04). These medical records

document the limited range of motion and lack of strength-“she is unable to fully grasp a door knob to open a door”, “Patient unable to close hand over my first to demonstrate turning a doorknob to open a door. Severe pain elicited on placing 2 of my fingers in her left palm in an attempt to demonstrate ability of her fingers to make a fist-could not do it”, “left wrist active-limited active range of motion pain”, “left wrist passive-decreased passive range of motion spasm”, “contracture: lack of full extension, lack full flexion”. Additionally, we have provided a letter stating had undergone 17 visits of physical therapy. Hence, the adverse determination is not supported. claims to lack medical records that clearly exist and are attached hereto. The medical necessity of the request for physical therapy is established.

08/14/2014: UR. Rational for Denial: The number of previously completed PT visits is still not provided. Hence, the medical necessity of the request is not established and the previous determination is upheld.

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

The previous determination is upheld. Denial of PT 2x6 is UPHELD/AGREED UPON since there is lack of clinical information. There is no submitted actual active Range of motion measurements in degrees of the wrist/s, nor manual muscle testing of the wrist/s, nor grip testing of the hand/s - neither before or after a reported 17 visits over approximately 4 months. Therefore, there is inability to gauge progress with the visits already completed so as to determine medical necessity of more visits. Therefore, the request for Physical Therapy 2xWk x 6Wks Left Upper Extremity (RSD) is non certified.

ODG:

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.
Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):
Medical treatment: 10 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment, arthroscopic: 24 visits over 14 weeks
Post-surgical treatment, open: 30 visits over 18 weeks
Complete rupture of rotator cuff (ICD9 727.61; 727.6)
Post-surgical treatment: 40 visits over 16 weeks
Adhesive capsulitis (IC9 726.0):
Medical treatment: 16 visits over 8 weeks
Post-surgical treatment: 24 visits over 14 weeks
Dislocation of shoulder (ICD9 831):
Medical treatment: 12 visits over 12 weeks
Post-surgical treatment (Bankart): 24 visits over 14 weeks
Acromioclavicular joint dislocation (ICD9 831.04)**:**
AC separation, type III+: 8 visits over 8 weeks
Sprained shoulder; rotator cuff (ICD9 840; 840.4):
Medical treatment: 10 visits over 8 weeks
Medical treatment, partial tear: 20 visits over 10 weeks
Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

Superior glenoid labrum lesion (ICD9 840.7)
Medical treatment: 10 visits over 8 weeks
Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks
Arthritis (Osteoarthrosis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)
Medical treatment: 9 visits over 8 weeks
Post-injection treatment: 1-2 visits over 1 week
Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks
Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):
Medical treatment: 14 visits over 6 weeks
Post-surgical treatment: 20 visits over 10 weeks

Fracture of clavicle **(ICD9 810):**

8 visits over 10 weeks

Fracture of scapula (ICD9 811):
8 visits over 10 weeks
Fracture of humerus (ICD9 812):
Medical treatment: 18 visits over 12 weeks
Post-surgical treatment: 24 visits over 14 weeks

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)**