INDEPENDENT REVIEW INCORPORATED

July 20, 2006

Re:	**MDR #:**	**M2 06 1587 01**	**Injured Employee:**	**___**
	DWC #:	**___**	**DOI:**	**___**
	IRO Cert. #:	**5055**	**SS#:**	**___**

TRANSMITTED VIA FAX TO:
TDI, Division of Workers' Compensation
Attention: ___
Medical Dispute Resolution
Fax: (512) 804-4868

RESPONDENT: **State Office of Risk Management**

REQUESTOR: **Lloyd Miller**

TREATING DOCTOR: **Eric Sides, MD**

In accordance with the requirement for DWC to randomly assign cases to IROs, DWC assigned this case to IRI for an independent review. IRI has performed an independent review of the medical records to determine medical necessity. In performing this review, IRI reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the office manager of Independent Review, Inc. and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the Independent Review Organization. Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. Your case was

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reviewed by a physician who is a board certified in anesthesiology with special qualifications in pain management and is currently listed on the DWC Approved Doctor List.

We are simultaneously forwarding copies of this report to the payor and the TDI, Division of Workers' Compensation. This decision by Independent Review, Inc. is deemed to be a DWC decision and order.

Your Right To Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on July 20, 2006.

Sincerely,

jc

Jeff Cunningham, DC
Office Manager

INDEPENDENT REVIEW INCORPORATED

REVIEWER'S REPORT
M2 06 1587 01

Information Provided for Review:

1. TWCC-1S dated 12/05/05
2. Right shoulder MRI scan dated 12/12/05
3. Medical records of Dr. Sides from 12/16/05 through 06/23/06
4. Physical therapy progress notes from 12/19/05 through 05/24/06

Clinical History:

This claimant was injured on ___ when he hit his right shoulder on a steel door. A right shoulder MRI scan was performed on 12/12/05 demonstrating degenerative changes in the acromioclavicular joint and a tiny tear of the anterior margin of the supraspinatus tendon. The patient was initially evaluated by Dr. Sides on 12/16/05, complaining of right shoulder discomfort and pain. He was given a cortisone injection of the right shoulder and referred for physical therapy. His initial evaluation for physical therapy was on 12/19/05, which demonstrated mild to moderate deficits in range of motion of the right shoulder. An initial request for physical therapy was made for 3 days a week for 4 weeks. The claimant completed 2 months of physical therapy on 02/17/06, at which time he demonstrated moderate reduction of range of motion for right shoulder abduction and mild reduction of range of motion of the right shoulder for all other planes of motion. The physical therapist discharged the claimant to a home program on 02/17/06. On 03/30/06, Dr. Sides performed right shoulder arthroscopic surgery consisting of subacromial decompression, rotator cuff repair, distal clavicle resection, and Bankart repair of the right shoulder. Postoperatively, Dr. Sides referred the claimant for physical therapy on 04/07/06. The claimant was evaluated for resumption of physical therapy on 04/11/06, complaining of a pain level of 8/10. Range of motion was documented as being minimal in all planes for the right shoulder. By 04/26/06, the physical therapist documented that the claimant had regained 120 degrees of passive mobility flexion. Dr. Sides recommended 3 days per week for 4 weeks of physical therapy with "no weights." On 05/03/06 the physical therapist documented that the claimant was "overreacting to pain and soreness." According to the physical therapist, the claimant was being progressed to an active exercise regimen. Dr. Sides, on that date, requested another 4 weeks of 3 times per week physical therapy consisting of "AROM," (active range of motion). On 05/05/06 Dr. Sides documented that the claimant's passive forward range of motion was "almost full." On 05/22/06 the physical therapist documented the claimant's

continued complaints of pain, but no pain level was documented. The physical therapist indicated the claimant still needed work for strength, mobility, and performing overhead reaching tasks. He indicated plans to continue using modalities including "moist heat, electrical stimulation, and cold packs" as well as manual therapy, strengthening, endurance and conditioning exercises. On that date, the documented ranges of motion continued to indicate moderate reduction in shoulder flexion, extension, abduction, adduction, internal rotation, and external rotation. On 05/26/06 Dr. Sides ordered 4 more weeks of physical therapy at 3 times a week with recommendation to "begin strengthening." Dr. Sides also documented that the claimant was "doing better" with "less pain and less discomfort." On 05/23/06 a request for continued physical therapy consisting of modalities, therapeutic exercise manual therapy, and therapeutic activity was reviewed by a physician adviser with recommendation for denial. A reconsideration of the request was then performed on 05/26/06 with recommendation again for denial based upon lack of current clinical information consisting of assessment by the doctor or physical therapist. On 06/23/06 the claimant was seen by Dr. Sides who again recommended further physical therapy specifically for his lack of strength. He noted that the claimant had "full passive motion." There was no physical examination performed or documentation of the claimant's pain level.

Disputed Services:

Physical therapy 3 times a week for 4 weeks of the right shoulder consisting of therapeutic exercises, manual therapy, electrical stimulation, ultrasound, and therapeutic activities

Decision:

I AGREE WITH THE DETERMINATION OF THE INSURANCE CARRIER IN THIS CASE.

Rationale:

There is no current objective evaluation by the requesting surgeon nor any recent physical examination documented by the requested surgeon of this claimant. Moreover, the requesting surgeon indicates that the claimant's need for physical therapy is based upon lack of strength. Additionally, the last prescription for physical therapy dated 05/26/06 from the requesting surgeon indicated the need to "begin strengthening." Based upon the surgeon's own documentation, therefore, there is no medical reason or necessity for any of the physical therapy modalities that have been requested, only medical reason and necessary for the claimant to be doing active exercise of the right shoulder for strengthening purposes. There is no medical reason or necessary, therefore, for therapeutic exercise, manual therapy, electrical stimulation, ultrasound, or "therapeutic activities" as requested by the physical therapy facility.

Screening Criteria:

Based upon accepted standards of care, it is appropriate for post arthroscopic physical therapy. However, in this case, based upon the minimal pathology identified at arthroscopy, according to the operative note, this claimant does not demonstrate any need for extraordinary amounts of physical therapy or rehabilitation above and beyond what would be considered usual and customary. Since the surgeon has himself indicated the claimant's need is for strengthening exercises, there is no medical reason or necessity for any of the physical therapy that has been requested and is the subject of this review, as the therapy that has been requested and is the subject of this review does not meet the surgeon's own stated requirement for strengthening of the claimant's right shoulder. Therefore, there is no medical reason or necessity for the physical therapy that has been requested, and I agree with the determination of the insurance carrier in this case.