

# Independent Resolutions Inc.

An Independent Review Organization

835 E. Lamar Blvd. #394

Arlington, TX 76011

Phone: 817-274-0868

Fax: 817-549-0310

Notice of Independent Review Decision

## **DATE OF REVIEW:**

AUGUST 16, 2007

## **IRO CASE #:**

## **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical therapy

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

Board Certified Orthopedic Surgeon

## **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)

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Emergency Department notes/hospital admission notes

Chest x-ray, 01/17/07

Brain CT scan, 01/22/07

Pelvic and lumbar spine x-ray, 01/24/07

Right ankle x-ray, 02/07/07

Left shoulder MRI, 02/16/07

Lumbar spine MRI, 02/16/07

Physical therapy evaluation, 03/01/07

Office notes, Dr. 05/03/07, 05/03/07

Office note, Dr., 05/21/07

Note, 06/18/07 and 07/16/07

Physical therapy note, 06/22/07

Peer review, 07/12/07 and 07/26/07  
Request for medical dispute resolution, 08/03/07  
Work status reports, undated

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a male who sustained multiple injuries when he fell twelve feet from a semi –truck on xx/xx/xx. He was seen in the emergency room and apparently had a short overnight hospital stay. His injuries included facial fractures, a left sided skull fracture with a small sub dural hematoma and a wedge-type compression fracture at L1. MRI of the left shoulder on 02/16/07 revealed an abnormal signal in the acromion, and the distal clavicle with edema suggestive of posttraumatic change. A non-displaced macro fracture of the scapulae/acromion could not be excluded. There was degenerative appearance of the hyaline cartilage in the glenoid, less likely post traumatic in nature. There was no evidence of a labral tear or effusion.

A lumbar MRI showed a wedge compression deformity in the L1 vertebral body with 20% loss of vertebral height and evidence of bone marrow edema. There were multiple facet arthroses and a left paracentral disc extrusion at L5-S1 effacing the left anterior epidural space and encroaching on the exiting nerve. A broad based disc bulge at L4-5 with annular rent was also noted.

The claimant began therapy on 03/06/07 for left shoulder and lower back complaints. An office note on 04/05/07 by Dr. noted marked improvement in the left shoulder, back and right leg. Motion in the shoulder was near full with mild impingement sign, The claimant was instructed to continue with work conditioning therapy for another month at which time the physician felt the claimant would be at maximum medical improvement. On 05/03/07, an office visit noted a fair amount of back and right leg pain persisted. A lumbar x-ray noted the L1 compression fracture. It appeared to be a sub acute process that may have been in place prior to the injury. Exam findings noted no motor or sensory loss in the lower extremities. The claimant was referred to pain management for possible injections.

Dr. saw the claimant on 05/21/07. On examination, motion was limited in the both shoulders with some focal weakness noted in the right lower extremity. The impression was lumbar radiculopathy and shoulder pain. Lumbar epidural steroid injections at L5 on the right were discussed. Continued therapy was prescribed.

The claimant completed approximately twenty-one therapy sessions since 03/06/07 with no noted change in subjective complaints of left shoulder and back pain. The request for continued therapy was not approved on two separate occasions and a request for a medical dispute resolution was submitted.

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

The reviewer was asked to review the information pertaining to this claimant. Request for therapy had been denied on 07/12/07 and 07/26/07 and a dispute resolution has been requested. .

The reviewer would agree with the denial recommendations. The claimant's date of injury was xx/xx/xx in which the patient fell 12 feet. The diagnosis included lumbosacral radiculopathy, compression fracture, and left shoulder pain. The claimant had extensive therapy. The claimant completed approximately 21 sessions since 03/06/07 with no change in subjective complaints regarding the back or left shoulder pain and as such it would appear that the benefits of formal therapy have been exhausted.

The reviewer would agree that further therapy is not indicated at this juncture due to the ongoing subjective complaints.

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates (Shoulder, Back)

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.

Fracture of vertebral column without mention of spinal cord injury

Medical treatment: 8 visits over 10 weeks

Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program

Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted;

Sprains and strains of shoulder and upper arm:

9 visits over 8 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)**