

Clear Resolutions Inc.

DATE OF REVIEW:

MARCH 23, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Under dispute is the prospective and/or concurrent, retrospective medical necessity of physical therapy three times per week for four weeks.

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

Board-certified Internal Medicine

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notification of Case Assignment, Medical Records from Respondent, Treating Doctor (s), including Drs. and, operative notes dated xx/xx/xx, 11/28/06, 12/15/06, 12/15/06, 1/9/07, 1/24/07, 2/14/07, radiographic imaging xx/xx/xx, and physical therapy notes.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient fell down some stairs and sustained a fracture of the left humerus. The initial treatment course is not provided. He underwent manipulation under anesthesia. MRI showed a partial tear of the rotator cuff. A physical therapy note from January 2007 does not document ROM, but does state the Patient "lacks 30 degrees of external rotation."

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

The Patient sustained an injury to the left shoulder in. The initial treatment is unknown. He underwent MUA. Physical therapy shows a minor deficit in external rotation. The Reviewer was unaware of how many sessions of therapy were provided.

The ROM is mildly decreased. The records do not support the need for further formal physical therapy. Thus, based on a thorough review of the medical records the Reviewer agrees with the determination of the Insurance carrier.

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)