



**IRO NOTICE OF DECISION - WC**

Notice of Independent Review Decision

**DATE OF REVIEW:**            08-14-07

**IRO CASE #:**

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

Physical Therapy 3 x 4 (12 sessions) for Left Shoulder

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

Certified by The American Board of Orthopedic Surgery  
General Certificate in Orthopedic Surgery

**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)

Injury Date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	959.3	099G0	12	Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Notice of Non-Certification dated 07-05-07

**IRO NOTICE OF DECISION - WC**  
**Page 2**

Notice of Non-Certification (Reconsideration) dated 07-23-07  
Left CT Shoulder without Contrast: 07-29-05  
Patient Information / Insurance dated 07-29-05  
Operative Report dated 08-02-05  
Physician Progress Notes 06-14-06, 05-16-07  
Record of telephone conversation dated 06-21-07  
Physician Prescription dated 07-25-07

**PATIENT CLINICAL HISTORY:**

This patient fell at work. CT left shoulder without contrast showed impacted left humeral head fracture. The claimant underwent open reduction internal fixation (ORIF) of left proximal fracture on 08-2005. There was no mention in the operative report of the status of the articular surface of the head nor glenoid, nor the rotator cuff and subscapularis. According to the records, the claimant on 06-14-06 complained of joint stiffness, swelling, numbness and weakness. Left shoulder range of motion (ROM): external rotation 46 degrees, external rotation 30 degrees at 90 degrees. She presented on 05-17-07 with complaints of pain unchanged, tingling and numbness. X-ray of left shoulder demonstrated humeral head spurring. The subacromial space was injected with Depomedrol and Marcaine. On 06-21-07, the claimant noted the shoulder injection helped only 4 days and the pain was the same as it was before. She also requested physical therapy for hand because of a pulled tendon.

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

In the opinion of Lumetra's Reviewer, the requested physical therapy sessions are not medically necessary for this claimant. The Reviewer concurred with the prior adverse determinations and noted that there is no documentation connecting the hand problem with the left shoulder injury of 07-26-05. There is no documentation / neurological study / examination to explain claimant's complaint of numbness. In addition, the documentation is unclear which hand is to be treated in physical therapy.

Criteria used: ODG Physical Therapy Guidelines

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

**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)**

**IRO NOTICE OF DECISION - WC**  
**Page 4**

**OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME  
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**