

Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: APRIL 8, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical Therapy, one (1) to two (2) times a week for three (3) weeks.

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

MD, 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

Adverse Determination Letters, 3/14/08, 3/20/08

ODG Guidelines and Treatment Guidelines

OTR, 3/18/08

MD, 3/3/08

COTA, 2/6/08, 2/8/08, 3/8/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The medical records indicate that the patient has had a shoulder sprain secondary to a work-related incident with subsequent adhesive capsulitis. There

are complaints of left anterolateral shoulder pain, left upper extremity loss of motion, and left upper extremity weakness.

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

The request is for physical therapy one to two times a week for three weeks. Based upon the clinical rationale and according to ODG Treatment Guidelines, the reviewer has upheld the previous adverse determination. There has been little recent progress in therapy. There is little support for physical therapy treatments at this point in the treatment regimen. Given the little recent progress, further structured therapy appears unwarranted, particularly not only under the ODG Guidelines but also under the well-accepted understanding that therapy is best and most beneficial in the first three to six months post injury. There is no evidence in the medical records provided that the patient has had manipulation under anesthesia or other recent treatments that would justify a formal therapy program rather than a home-based self-monitored exercise program.

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)**