

SENT VIA EMAIL OR FAX ON  
Mar/24/2009

## P-IRO Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/23/2009

**IRO CASE #:**

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

Work Hardening 5 wk X 4 wks

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

Board Certified in Physical Medicine and Rehabilitation  
Subspecialty Board Certified in Pain Management  
Subspecialty Board Certified in Electrodiagnostic Medicine  
Residency Training PMR and ORTHOPAEDIC 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines  
Denial Letters 1/22/09 and 2/19/09  
Records from Pain & Recovery 11/12/08 thru 3/6/09  
Record from Dr. 1/13/09  
FCE 2/13/09  
Spine & Rehab 9/26/08 thru 12/30/08  
Records from Dr. 10/15/08 thru 1/28/09  
MRI 10/21/08  
Advanced Invasive Pain 10/28/08  
Diagnostic 10/29/08  
Dr. 1/9/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a lady who was injured. The Reviewer could not determine if she is left or right handed. She fell at work (xx/xx/xx- Another note described a xx/xx/xx fall). She reportedly landed on her left hand/shoulder and sustained a dislocated left shoulder. This was reduced at General Hospital. She remained with pain. An MRI 2 weeks later showed a comminuted

left greater tuberosity fracture. This was treated with immobilization. An EMG performed on 10/29/08 reported showing spontaneous activity in her deltoid, biceps, triceps, ECR, brachioradialis, abductor pollicis brevis and first dorsal interosseous. This was interpreted as injury to the posterior, medial and lateral cords (brachoplexopathy). Mr., a PA, described a normal neurological examination on 10/28. The examinations by Dr. in January 2009 described sensory reduction and complaints in the left third, fourth and fifth digits. He described limited shoulder motion. A prior reviewer described 21 sessions of physical therapy.

Her FCE on 1/12/09 showed her to be at a light Physical Demand Level, but her work requires her to be at a Heavy PDL. She apparently has a job to return to. She was felt to have no psychological contraindications with evaluation. Dr. described her as having reduced shoulder motion and pain in his January notes.

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

The EMG about the shoulder could be abnormal as a result of the local muscle trauma. The hand findings could be related to her old CTS. The forearm findings, however, support the possible brachio-plexopathy. The immobilization for the fracture and dislocation could be contributing to a frozen shoulder. Her ranges of motion were markedly reduced. The ODG does permit physical therapy for these conditions. These follow

##### ODG Physical Therapy Guidelines (shoulder)

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 week

Adhesive capsulitis (IC9 726.0)

Medical treatment: 16 visits over 8 week

Dislocation of shoulder (ICD9 831)

Medical treatment: 12 visits over 12 week

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0)

Medical treatment: 14 visits over 6 week

Fracture of humerus (ICD9 812)

Medical treatment: 18 visits over 12 week

Post-surgical treatment: 24 visits over 14 week

Work conditioning (See also Procedure Summary entry)

10 visits over 8 weeks

She has completed the limits on physical therapy. Her FCE showed that she has the functional loss of strength. It is not clear if the work hardening would improve the motion of her shoulder. The goal is to improve her strength and stamina to return to her job. There reportedly is a job available. The request is for 4 weeks of treatment, 5 times a week. The ODG only justifies 1-2 weeks with a continued program if there is documentation of participation and progress. The request is for 4 weeks of treatment, and the Reviewer's instructions are to approve all or none. The ODG will only justify an initial 1-2 weeks of treatment. Therefore, the Reviewer cannot approve the 4 weeks of treatment.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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