



- Store Instructional Form dated 5/4/10.
- Han/ Upper Extremity Evaluation dated 5/3/10.
- Texas Worker's Compensation Work Status Report dated 4/26/10., 2/17/10, 1/11/10, 12/21/09, 7/7/09, 6/29/09, and 2/13/08.
- Order Requisition dated 4/26/10.
- Evaluation dated 4/26/10, 2/17/10, 1/11/10, and 12/21/09, 7/7/09, 6/29/09.
- Offer dated 7/7/09.
- Texas Worker's Compensation Work Status Report dated 4/6/09, 11/10/08.
- Progress Note dated 4/6/09, 11/18/08, 8/12/08, 7/15/08.
- Registration Form dated 2/26/09.
- Patient Notes 2/16/09.
- Physical Exam dated 2/16/09.
- Follow Up dated 3/5/08, 2/13/08, 1/21/08.
- Patient Status dated 2/13/08.
- Physical Therapy Dept. Daily Note dated 2/4/08, 2/1/08, 1/30/08, 1/28/08, 1/23/08.
- Physical Therapy Evaluation dated 1/23/08.
- Initial Visit Notes dated 1/14/08.
- Employer's First Report of Injury or Illness dated xx/xx/xx
- Office / Outpatient Visit dated xx/xx/xx.
- There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender:**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Lifting a bag of dog food**

**Diagnosis: Thoracic strain, right wrist strain, right shoulder strain**

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

This female was originally injured on xx/xx/xx and was noted to have injured her thoracic spine and right wrist lifting a bag of dog food. The patient was initially evaluated on xx/xx/xx by M.D., and diagnosed with thoracic strain, right wrist strain and right shoulder strain and started in physical therapy (PT) and prescribed medications that included Relafen and Ketoprofen cream. The patient subsequently was seen by Dr. on 4/6/09, who noted the chronic shoulder condition and recommended an MRI. The patient then was seen by Dr. on 7/7/09, who noted positive impingement, weakness with flexion and abduction, and the prior conservative treatment of anti-inflammatories and PT with no improvement and recommended an MRI. Dr. continued to follow this patient, noting ongoing physical examination findings to remain constant and continuing to request an MRI of the shoulder. The most current examination by Dr. was on 4/26/10, where he noted continued weakness in abduction and flexion. External

rotation at 90 caused discomfort and mildly positive impingement sign. He scheduled the patient for PT noting the MRI continued to be refused. The peer review in consideration of the requested occupational therapy recommended non-certification indicating the patient previously had a course of PT authorized at the time of the incident and was released by Dr. on 2/13/08. The patient was noted to have been independently doing the home exercise two years ago with the initial treatment. The rationale for the adverse determination of requested occupational therapy, three times a week for four weeks for the right shoulder to include CPT Codes 97110, 97014, and 97140, is the patient has previously had occupational therapy or PT in relation to this injury, was independent in home exercises, and was released by the original treating physician in February 2008. At this time, the medical records do not contain a clinical rationale why this patient now should have further PT as there is no rationale as to why this patient is not capable of a home exercise program to address her deficits. Official Disability Guidelines do not recommend use of 97041 (electrical stimulation), stating: "The most commonly used active treatment modality is **Therapeutic exercises (97110)**, but other active therapies may be recommended as well, including **Neuromuscular reeducation (97112)**, **Manual therapy (97140)**, and **Therapeutic activities/exercises (97530)**. Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies."

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).