

SENT VIA EMAIL OR FAX ON  
Aug/30/2010

## IRO Express Inc.

An Independent Review Organization

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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Aug/30/2010

**IRO CASE #:**

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

Continue Physical Therapy 3 X week X 4 weeks

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

Board certified in Physical Medicine and Rehabilitation with expertise in pain management, wound management and geriatrics.

**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 7/21/10 and 7/8/10

PT 5/24/10 thru 7/6/10

**PATIENT CLINICAL HISTORY SUMMARY**

This worker reported pain in the left shoulder. She has had physical therapy for a shoulder strain. Shoulder flexor strength is 4/5, extensors are 4+/5 and abductors are 4/5 she did improve with physical therapy. She was to have a follow up with her orthopedist to determine need for further treatment. There had not been a follow up md appointment.

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

There is strong evidence that physical methods including exercise and return to normal activities have the best long term outcome in employees with pain. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider. Physical therapy should allow for fading frequency of treatments with

transition to a home exercise program as recommended by the guidelines. For SHOULDER STRAIN, 10 visits of physical therapy are recommended by the ODG. This patient has exceeded those visits and there is no indication that a home exercise program cannot be implemented

The ODG recommends that the treatment be goal oriented and progress be noted with follow up from a treating physician to implement the treatment plan.

**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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

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