

SENT VIA EMAIL OR FAX ON  
Aug/15/2011

## Independent Resolutions Inc.

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

**DATE OF REVIEW:**  
Aug/12/2011

**IRO CASE #:**

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

1. PT Left Shoulder/Wrists/Cervical X 12 sessions, 4 units per session; 2. Manual Therapy Left Shoulder/Wrists/Cervical X 12 sessions, 1 unit per session 3. Interferential Therapy Left Shoulder/Wrists/Cervical X 12 sessions, 1 unit per session 4. Joint Mobilization Therapy Left Shoulder/Wrists/Cervical X 12 sessions

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

M.D., Board Certified Family Practice

**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**

**PATIENT CLINICAL HISTORY SUMMARY**

The injured employee is a female whose date of injury is xx/xx/xx. Records indicate she was moving shopping carts in parking lot when the car hit the carts and the carts hit the injured employee's left shoulder / arm. The injured employee was treated in the ER where x-rays were negative for any fracture. The injured employee was prescribed medications but did not fill. She was placed in sling and instructed in home exercises. The injured employee received chiropractic treatment x 16 visits on 05/02/11-06/08/11. Treatment included ultrasound, massage, moist heat, interferential stimulation, and joint mobilization.

A utilization review determination dated 06/23/11 determined that request for continued physical therapy left shoulder / wrist / cervical x 12 sessions, 4 units per sessions; 2) manual therapy left shoulder / wrists / cervical x 12 sessions, 1 unit per session; 3) Interferential therapy left shoulder / wrists / cervical x 12 sessions, 1 unit per session; 4) joint mobilization therapy left shoulder / wrists / cervical x 12 sessions was non-certified. It was noted the injured employee had complaints of neck, left shoulder, and left hand pain. X-rays were apparently negative. On 05/10/11 exam there was paracervical muscle tenderness, limited motion of left shoulder, and difficulty with raising the arm over head. The injured employee was diagnosed with left shoulder strain, neck strain and left wrist strain. A trial of therapy has

been authorized. Clinic note dated 06/08/11 was reviewed and exam showed cervical and left wrist tenderness, cervical flexion / extension 45 / 35, and left shoulder flexion / abduction 135/85. There was no documentation of attendance or response to prior therapy, and the request is now for 12 more therapy sessions. Adverse determination was recommended as there was no information regarding response to prior therapy, and it was unclear if additional therapy would be warranted.

Utilization review determination dated 07/01/11 determined the request for reconsideration of additional supervised rehabilitation of 12 sessions for the neck, left shoulder and wrist to be non-certified. On 06/28/11 the request for reconsideration was reviewed and documents that the injured employee has not had prior supervised rehabilitation. However, the injured employee was approved for 6 visit clinical trials at same facility on 05/19/11. It was noted that the injured employee has completed 6 supervised rehabilitative sessions to date, but there was no evaluation of the injured employee after 6 visit trial as required by ODG. Thus, additional supervised rehabilitation is not supported by ODG. It was noted that the requesting provider's statement of 06/28/11 that the injured employee has had no prior supervised rehab is not accurate.

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

Based on the clinical information provided, medical necessity is not established for the proposed treatment. It is noted the injured employee sustained an injury to left upper extremity / shoulder on xx/xx/xx. She complained of left wrist, left shoulder, and neck pain. From 05/02/11-06/08/11 the injured employee completed 16 visits of chiropractic treatment, which included most of the modalities currently requested including manual therapy, interferential therapy, and joint mobilization therapy. Records indicate the claimant injured employee was authorized for a trial of 6 sessions of physical therapy; however, there is no

documentation of the injured employee's response to active therapy. Given the current clinical data, medical necessity is not established as there is no objective evidence of functional improvement in response to treatment. It was also noted that subsequent imaging studies revealed a full thickness tear of the supraspinatus tendon of left shoulder with moderate impingement upon the subacromial space. Cervical spine MRI revealed multilevel central canal stenosis with foraminal narrowing. It appears the injured employee was referred for orthopedic surgical consultation, but it is unclear if this orthopedic consultation / evaluation has been completed.

**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)

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