SENT VIA EMAIL OR FAX ON
Aug/19/2011

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Aug/19/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
12 sessions (3 times a week for 4 weeks) of additional physical therapy for the left shoulder

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines

1. Cover sheet and working documents
2. Physical therapy evaluations and treatment notes 06/13/11-07/14/11
3. Progress notes 06/23/11 and 07/14/11
4. Adverse determination letter dated 07/19/11
5. Adverse determination letter dated 07/28/11

PATIENT CLINICAL HISTORY SUMMARY
The injured employee is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as a physical altercation. Conservative treatment to date includes at least 9 sessions of physical therapy and over the counter medications. On physical therapy evaluation dated 06/13/11 the injured employee is reported to have 5/10 dull throbbing constant pain. Left shoulder active range of motion with flexion is reported to be 110

degrees, abduction 90 degrees, IR 30 degrees, and ER 15 degrees.

The injured employee was seen for left shoulder evaluation on 06/23/11 by Dr. On physical examination the skin is warm, dry and intact. There is no evidence of abrasions, laceration, erythema, edema or discharge. She is tender in the anterolateral aspect of her shoulder and does have pain with range of motion. Forward flexion on this date was to 95 degrees, abduction 90 degrees, external rotation 50 degrees, and internal rotation to her SI joint. She has 4+/5 rotator cuff strength and radial pulse is 2+ and palpable. She is assessed with a left rotator cuff strain.

The injured employee was seen for follow-up physical therapy evaluation on 07/14/11. On this exam the injured employee's range of motion is 140 degrees with forward flexion, 110 degrees abduction, 40 degrees internal rotation and 25 degrees external rotation. The injured employee was reported to have some objective improvements, but minimal subjective improvement in pain or activities of daily living.

The injured employee was seen for final evaluation on 07/14/11 by Dr. On physical examination the left shoulder reveals diffuse tenderness around the shoulder joint. She is limited with active range of motion secondary to pain and stiffness. Range of motion on this exam is reported as forward flexion 165 degrees, abduction 160 degrees, external rotation 80, and internal rotation to L5-S1. Mild capsular restrictions were noted. No instability is detected. Neurovascular exam is grossly unremarkable. Impression at this time is left shoulder rotator cuff strain and suspect left shoulder early adhesive capsulitis. A request was placed for 12 additional sessions of physical therapy.

The initial request was reviewed on 07/19/11 by, M.D. She non-certified the request indicating that the claimant has already had 9 physical therapy sessions and range of motion is minimally improved. She indicates she should be doing active home exercises.

The appeal request was subsequently reviewed on 07/28/11 by, M.D. Dr. non-certified the request and indicates the ODG Guidelines would support 9 physical therapy sessions over 8 weeks. The claimant has undergone 9 physical therapy sessions and has good active range of motion. He indicated that the clinician has not described the clinical necessity for ongoing formal therapy at this point versus an aggressive home exercise program.

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

Based on the clinical information provided, the request for 12 sessions (3 times a week for 4 weeks) of additional physical therapy for the left shoulder is not recommended as medically necessary, and the two previous denials are upheld. The patient has completed at least 9 sessions of physical therapy to date. The Official Disability Guidelines support up to 9 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Given the current clinical data, the requested physical therapy is not indicated as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES