

Prime 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Dec/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 4Wks; Left Shoulder

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

M.D., Board Certified Orthopedic Surgeon

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

Official Disability Guidelines

Dr. office notes: 08/23/10, 09/03/10, 11/02/10

Physical Therapy notes: 09/13/10, 10/22/10

Peer Review: 11/11/10, 11/22/10

Denial Letters: 11/11/10, 11/22/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained a work related injury to her left shoulder on xx/xx/xx. The claimant suffered a left shoulder sprain/contusion as a passenger in a car involved in a motor vehicle accident. The claimant attended 11 physical therapy sessions. When she saw Dr. on 11/02/10, her pain had started to resolve and she had normal active and passive range of motion. The request for 12 additional physical therapy sessions was noncertified in two peer reviews. Dr. noncertified the request on 11/11/10 as the claimant had already exceeded the number of visits allowed and there was no indication that the remaining deficits could not be addressed by an independent home exercise program. In a second peer review on 11/22/10, Dr. noncertified the additional physical therapy sessions as Dr. office note of 11/01/10 indicated that the claimant had full range of motion and the claimant had already participated in 11 sessions.

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

This reviewer agrees with upholding the denial for additional physical therapy as not

medically necessary at this time. The patient has already had greater than 10 visits over 8 weeks, has normal active and passive range of motion with only mild pain. At this time the ODG would recommend that the patient focus on a home exercise program for terminal range of motion, strength and comfort relief. There is nothing to suggest progressive neurologic deficits. The patient has already exceeded guideline recommendations. The reviewer finds that medical necessity does not exist for Physical Therapy 3xWk x 4Wks; Left Shoulder.

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)