

SENT VIA EMAIL OR FAX ON
Jul/21/2011

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jul/21/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy Cervical Spine Left Shoulder, Left Wrist x 12 visits, 4 units per session;
Myofascial Release Therapy Cervical Spine, Left Shoulder, Left Wrist x 12 visits, 1 unit per
session; Electrical Stimulation Therapy Cervical Spine, Left Shoulder, Left Wrist x 12 visits, 1
unit per session; Joint Mobilization Therapy Cervical Spine, Left Shoulder, Left Wrist x 12
visits, 1 unit per session

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

Board Certified PMR and Pain Management

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 patient is a male whose date of injury is xx/xx/xx. On this date the patient was hit by an F150 on his left hand while sweeping. The impact jolted his arm and neck to the side. Initial evaluation dated 05/11/11 indicates that the patient has not received any physical therapy or injections. The patient is status post neck and low back surgery several years ago.

Diagnoses are cervical sprain/strain, lumbar strain/sprain, rotator cuff sprain/strain, wrist strain/sprain, neuralgia, rotator cuff syndrome and adhesive capsulitis. MRI of the left wrist dated 06/22/11 revealed no acute internal derangement; altered positioning of the pisiform which may be secondary to remote trauma or a congenital variant. MRI of the left shoulder revealed low grade interstitial tearing of the humeral insertional fibers of the supraspinatus tendon with low-grade articular sided tearing of the humeral insertional fibers of the subscapularis tendon; laterally-downsloping acromion process with subacromial/subdeltoid bursitis, all suspicious for external impingement syndrome.

Initial request was non-certified on 05/19/11 noting that there are no interval medical records submitted for review. There is no established need for supervised rehab 6 months after the date of injury. The patient was reasonably expected to have been independent with a home exercise program months ago. The denial was upheld on 06/02/11 noting that there is no detail regarding prior treatment. It remains unclear why monitored therapy would be medically necessary greater than x months out from the reported date of injury and for which the patient should have been placed on a home exercise program some time ago.

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 Physical therapy cervical spine, left shoulder, left wrist x 12 visits, 4 units per session; myofascial release therapy cervical spine, left shoulder, left wrist x 12 visits, 1 unit per session; electrical stimulation therapy cervical spine, left shoulder, left wrist x 12 visits, 1 unit per session; joint mobilization therapy cervical spine, left shoulder, left wrist x 12 visits, 1 unit per session is not recommended as medically necessary, and the two previous denials are upheld. The patient sustained injuries approximately x months ago. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no clear rationale provided to support 12 supervised physical therapy visits at this point in time. There are no specific, time-limited treatment goals provided. The patient should have been instructed in and transitioned to an independent, self-directed home exercise program months ago, as the guidelines recommend.

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

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

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES