

Prime 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Oct/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT three times a week for six weeks for the right shoulder

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

M.D., Board Certified Orthopedic Surgery

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
Utilization review determination dated 09/16/11
Utilization review determination dated 09/29/11
Fax cover sheet dated 09/14/11
Physical therapy prescription dated 09/07/11
Physical therapy evaluation dated 09/13/11
Clinical records Dr. dated 05/09/11, 09/07/11, 10/06/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained injuries to her right upper extremity on xx/xx/xx. She was seen in ER where she was provided posterior sling and x-rays were performed. On physical examination she is noted to be 56 inches tall and weigh 220 lbs. She has tenderness at proximal humerus. Swelling is minimal at humeral fracture site. There is ecchymosis which is minimal. Range of motion testing is not performed. Radiographs of shoulder noted fracture of surgical neck, which is in satisfactory alignment. Fracture fragments are minimally displaced. Dr. saw the claimant in follow-up on 09/07/11. She complains of stiffness, waking up at night, shoulder pain and weakness. She has been in physical therapy for a month. On physical examination external rotation was 35 degrees, abduction 100, internal rotation is possible to level of sacral plane. Radiographs show healed fracture. She is to return in one month and begin rotator cuff strengthening protocol. The claimant was seen in follow-up on 10/06/11. Her subjective complaints are unchanged. External rotation is 35 degrees, abduction to 110, and internal rotation level of sacrum. Physical therapy evaluation was performed on 09/13/11. She is noted to globally have 4/5 strength. Range of motion is 110 degrees flexion, 40 degrees extension, abduction 70-100 degrees, and internal rotation is 45. External rotation is 30 degrees. She has completed 12 sessions of PT.

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

The submitted clinical records indicate the claimant sustained a proximal humerus fracture as result of work place event. She has been treated conservatively, and has had 12 sessions of therapy to date. Current evidence based guidelines would support up to total of 18 sessions. This request is for 18 additional sessions that would exceed the guidelines recommended in ODG. No exceptional factors have been noted. The reviewer finds there is not a medical necessity for PT three times a week for six weeks for the right 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)