SENT VIA EMAIL OR FAX ON
Jun/07/2012

Independent Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jun/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
8-10 sessions of initial physical therapy for the right 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
Cover sheet and working documents
Utilization review determination dated 04/19/12, 05/01/12
Re-evaluation dated 04/12/12, 04/05/12, 02/09/12, 05/10/12

PATIENT CLINICAL HISTORY SUMMARY
The patient is a female whose date of injury is xx/xx/xx. On this date the patient injured her right shoulder at work sliding a glass door open. The earliest evaluation submitted for review is dated 02/09/12. The patient has a flare-up of right shoulder pain. The patient reports that she has had to do a lot of work over the last few days and over the weekends she works sometimes 10, 11 or 12 hours complaining of discomfort and pain over the right shoulder. Diagnosis is disorders of bursae and tendons in shoulder region unspecified. Re-evaluation dated 04/12/12 indicates that medications are Naprosyn and polar frost topical ointment. On physical examination no winging of the scapula is noted and minimal to no atrophy is noted.

Active range of motion of the right shoulder is flexion 95, abduction 100, internal rotation 70 and external rotation 70 degrees. Strength is 4-/5 grossly in the upper extremities.

Initial request for physical therapy was non-certified on 04/19/12 noting that the request is excessive as it is for 12 sessions and ODG would support ten visits over eight weeks. The claimant has good range of motion and strength. Records do not reflect the necessity for a supervised formal therapy versus a home exercise program. The denial was upheld on appeal dated 05/01/12 noting that there is no additional information provided by the treating provider that would result in an overturn of the previous non-certification. The claimant has good range of motion and good strength on physical examination. The treating provider has not described the clinical necessity for ongoing formal supervised physical therapy versus a self-directed home exercise program for this near one year old injury.

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 8-10 sessions of initial physical therapy for the right shoulder is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear how many sessions of physical therapy the patient underwent after the initial injury occurred. The patient’s compliance with a structured home exercise program is not documented. There are no specific, time-limited treatment goals provided. On physical examination the patient has good range of motion and good strength. Given the current clinical data, the requested physical therapy is not indicated as medically necessary.

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

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

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)