

# Clear Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jan/20/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT 3 x 4 right shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for PT 3 x 4 right shoulder is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 12/16/13, 11/15/13

Progress note dated 11/11/13

Handwritten soap note dated 11/13/13, 11/12/13, 11/11/13, 11/07/13, 11/06/13, 11/05/13, 10/31/13, 10/30/13, 10/29/13, 10/26/13, 10/23/13, 10/22/13

Initial evaluation dated 10/16/13

Exercise flow sheet dated 10/22/13-11/13/13

Letter dated 12/19/13

Follow up note dated 11/12/13, 12/10/13, 10/14/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient felt a pulling sensation in the superior portion of the shoulder and also in the right side of the neck. Note dated 10/14/13 indicates that the patient underwent one cortisone injection with relief. EMG/NCV reportedly did not show any evidence of neurologic compromise. Initial evaluation dated 10/16/13 indicates that active range of motion is internal rotation 20 and external rotation 45 degrees. Strength is 4 in flexion, 5- biceps, 4- triceps. Progress note dated 11/11/13 indicates that the patient has completed 10 of 12 authorized physical therapy visits. On physical examination internal rotation is 70 and external rotation is 70 degrees. Right shoulder strength has improved from 4- to 5. Note dated 12/10/13 indicates that elevation is to 160 degrees, external rotation to 55 degrees, and internal rotation to the T12 level.

Initial request for PT 3 x 4 was non-certified on 11/15/13 noting that the patient was injured 6 weeks ago and is presumed to have undergone some type of treatment to date. Relevant clinical information is lacking, including imaging results (if any), treatment to date, and response thereto. Additionally, it remains unclear if this is a cervical or shoulder injury. The

denial was upheld on appeal dated 12/16/13 noting that exam in November 2013 showed nearly full motion. Patient has had 11 visits of PT. There is no updated exam since 11/12/13. There is a request for PT with multiple passive modalities including 97035, 97010, G0283, A4556, 97112 that are not recommended per evidence based guidelines. The request exceeds evidence based guidelines.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been authorized for 12 physical therapy visits to date. The Official Disability Guidelines Shoulder Chapter supports up to 10 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. As such, it is the opinion of the reviewer that the request for PT 3 x 4 right shoulder is not recommended 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

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)