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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/14/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: additional PT 12 visits to right shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., 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)

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 additional PT 12 visits to right shoulder is not recommended as medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient was attempting to get up from the commode and slid on a wet floor and hit the partition between stalls and landed on the floor. MRI of the right shoulder dated 07/02/14 revealed acute Hills-Sachs fracture. This likely relates to prior anterior glenohumeral dislocation; 4.5 mm high grade partial thickness tear of the distal supraspinatus tendon; mild intramuscular edema/stranding within the distal infraspinatus and to a lesser extent but within the teres minor; and moderate acromioclavicular arthrosis. Re-evaluation dated 09/08/14 indicates that the patient has completed 13 physical therapy visits to date. Pain is rated as 5/10. She has been scheduled to undergo cervical decompression and fusion, but surgery has been postponed. The patient is status post cortisone injection x 2. On physical examination right shoulder strength is -4/5 in abduction, 4/5 flexion and external rotation and +4/5 internal rotation. Right shoulder range of motion is flexion 105, abduction 85 and external rotation 20 degrees.

Initial request for additional PT 12 visits to the right shoulder was non-certified on 08/18/14 noting that the guidelines would support up to 12 visits of physical therapy for the patient's diagnosis. The claimant has been certified for 12 sessions of physical therapy to date. No substantial documentation of subjective reports of pain, weakness or range of motion deficits were noted after 9 sessions, as per the progress report dated 08/07/14. The denial was upheld on appeal dated 09/15/14 noting that guidelines note that up to a total of 15 treatments with objective evidence of ongoing progress toward functional goals of physical therapy is recommended. The patient has had 13 visits of physical therapy as of 09/08/14. The claimant had some gains in strength and range of motion. Thus, a few additional sessions of care may be indicated; however, the request for 122 visits is not supported by guidelines.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained a right shoulder injury on xx/xx/xx and has completed at least 13 physical therapy visits to date. The Official Disability Guidelines support 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 additional PT 12 visits to 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)