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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/10/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: physical therapy 12 sessions for the left shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DC, Licensed Chiropractic Examiner

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. Physical therapy 12 sessions for the left shoulder is not indicated as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his left shoulder when he had a slip and fall on xx/xx/xx. The therapy note dated 05/04/15 indicates the patient able to demonstrate 2+/5 strength throughout the left shoulder. The patient was identified as having a positive Neer's and empty can test. The patient also was identified as having a positive painful arc of motion. The patient was able to demonstrate 95 degrees of left shoulder flexion, 86 degrees of abduction, and 55 degrees of external rotation. The clinical note dated 05/15/15 indicates the patient continuing to work at light duty. There is an indication the patient had undergone an injection and had initiated physical therapy at that time. The note indicates the patient utilizing Ibuprofen for ongoing pain relief. The patient was able to demonstrate 110 degrees of left shoulder abduction and 170 degrees of flexion at that time. The clinical note dated 06/15/15 indicates the patient continuing with left shoulder symptoms. The patient continued with the use of physical therapy as well as pharmacological interventions. The therapy note dated 06/25/15 indicates the patient having completed 10 physical therapy sessions to date. Range of motion deficits continued throughout the left shoulder. The therapy note dated 06/30/15 indicates the patient rating his left shoulder pain as 0-1/10. Specific movements throughout the shoulder were exacerbating the pain level. The therapy note dated 07/02/15 indicates the patient having completed 12 physical therapy sessions to date. The note indicates the patient able to demonstrate 154 degrees of left shoulder flexion with 155 degrees of abduction and 50 degrees of external rotation. The patient also demonstrated strength improvements to 3-/5.

The utilization reviews dated 06/30/15 and 07/13/15 resulted in denials for additional physical therapy as the patient was continuing with significant weakness throughout the left shoulder.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient

complaining of ongoing left shoulder strength deficits. There is an indication the patient had demonstrated range of motion improvements through the initial course of 12 physical therapy sessions. However, the clinical notes indicate the patient continuing with significant strength deficits. There is an indication the patient has undergone an MRI; however, the MRI results were not submitted for review. While the patient is continuing with significant strength deficits at the left shoulder, it does not appear the patient has made significant progress in terms of eliminating the strength deficits. Given the patient having completed a full course of 12 physical therapy sessions to date and taking into account the inadequate information regarding the patient's significant pathology confirmed by imaging studies as well as the inadequate strength improvements, this request is not indicated as medically necessary. As such, it is the opinion of this reviewer that the request for Physical therapy 12 sessions for the left shoulder is not indicated as medically necessary and the prior denials are upheld.

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)