

## Notice of Independent Review Decision

**DATE OF REVIEW:** 6/22/2016

**IRO CASE #**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Additional 9 sessions of physical therapy services for the left shoulder.

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

**M.D. Board Certified in Physical Medicine and Rehabilitation.**

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld	(Agree)
Overtured	(Disagree)
Partially Overtured	(Agree in part/Disagree in part)

**PATIENT CLINICAL HISTORY [SUMMARY]**

Patient is a female born on XX/XX/XX who was working in XX and was pushed by a XX on XX/XX/XX. She complained of shoulder pain and had 12 sessions of physical therapy. On XX/XX/XX she had 114 degrees of shoulder flexion and 115 degrees of shoulder abduction. There is a request for additional 9 sessions of physical therapy services for the left shoulder. On XX/XX/XX, her medications included flexeril, Flonase and Lexapro.

**ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS.**

Per ODG references, the requested "Additional 9 sessions of physical therapy services for the left shoulder" is not medically necessary. The ODG guidelines support the use of PT for a shoulder sprain/impingement. Ten visits over eight weeks is recommended. The progress of function in therapy is to be documented. The patient is to be transitioned to HEP.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

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

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