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**DATE NOTICE SENT TO ALL PARTIES:** Mar/08/2016

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT 2-3x4 Left shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** DO 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 PT 2-3x4 Left shoulder is not recommended as medically necessary

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is XX/XX/XX. The patient was hanging banners when her right foot became twisted in cords and she fell off the stage. She landed on her left side, striking her head and low back and bouncing off the carpet. Orthopedic consultation indicates impression of cervical sprain/strain with upper extremity radiculitis, lumbar sprain/strain with lower extremity radiculitis, left SI joint strain, left shoulder sprain/strain. The patient was recommended to be started on an aggressive physical therapy program. MRI of the cervical spine revealed central/left central disc herniation at C4-5 resulting in cord compression and central stenosis. There is a central disc herniation at C6-7 causing central stenosis. Note indicates that she has been participating in a physical therapy program with some improvement. Designated doctor evaluation indicates that the patient has completed at least 5 physical therapy visits to date. The patient was determined not to have reached maximum medical improvement, and additional physical therapy was recommended. Office visit indicates that the patient rates her left shoulder pain at 8/10. Current medications are Mobic, tizanidine, tramadol and Tylenol-codeine. On physical examination left upper extremity deep tendon reflexes are 2+ biceps, 2+ triceps, 1+ brachioradialis. There is diminished sensation in the C6 dermatome on the left. Left shoulder range of motion is painful. Hawkins impingement is positive. Neer impingement is positive. Strength is 5/5 in flexion, abduction, internal and external rotation. The patient was recommended to continue physical therapy for the left shoulder.

Initial request for PT 2-3 x 4 left shoulder was non-certified noting that the patient's objective functional response to prior physical therapy was not documented for review. Missing information includes the total therapy attempted, efficacy of prior care and exceptional factors for ongoing supervised therapy at this time.

The denial was upheld on appeal noting that as per ODG, the recommendation is for 10 visits for sprained shoulder. Details regarding prior therapy such as the total number of sessions completed to date, dates of service and objective functional response would be needed to determine if further PT for the left shoulder is supported.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a left shoulder sprain/strain as a result of a fall and has completed 5 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. When treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The patient sustained a sprain/strain injury which should have resolved at this time. 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 2-3x4 Left shoulder is not recommended 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)