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Notice of Independent Review Decision

DATE NOTICE SENT TO ALL PARTIES: X

IRO CASE #: X

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

X.

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

X.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

X.

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a X who sustained an industrial injury on X and is seeking authorization for X. Prior diagnostic testing included x-rays of the left shoulder dated X, as noted on the X exam, has impressions of a negative exam. Magnetic resonance imaging of the left shoulder, as noted on the X exam, X.

Past Medical history includes X.

Previous treatment has included X. X Progress report dated X has the injured worker with left shoulder pain. X was X. X went to X. X has been having pain since this X. The pain is intermittent and is dull, achy, and sharp. The exam of the left shoulder reveals X. There is a X. The range of motion is (active/passive) forward elevation X, external rotation with arm in abduction X, external rotation with arm in adduction X, and internal rotation to the buttock. Rotator cuff strength is X in forward X. Mild to moderate tenderness of the X. Speed's and Yergason's are X. X is noted. There is a X. The treatment plan included an X.

Physical Therapy Initial Evaluation dated X has the injured worker having sustained a left shoulder injury. Currently X pain comes and goes and seems to occur with reaching and excessive movement/activity. The pain is pulling and aching and is located at the

anterior and superior aspect of the shoulder. X is on light duty. X pain is rated X. The left shoulder active range of motion is flexion X, extension X, abduction X, internal rotation X, and external rotation X. There is X. Horizontal abduction is X. Empty can, Hawkin's-Kennedy, and Neer's are X. Flexibility restrictions are noted to be X. Joint mobility restrictions are noted to X. Myofascial restrictions are noted to be X. Manual muscle testing is X on the left flexion, extension, abduction, internal rotation, and external rotation. Left mid and lower trap X and right mid and lower trap X. The treatment plan included X. Prognosis is excellent. Physical therapy daily note dated X has the injured worker noting no pain. Modalities on this date was moist heat x5 minutes to the right shoulder. X was issued. X tolerated X first full follow-up physical therapy session well without any increase in shoulder pain. X was provided a X.

X Progress report dated X has the injured worker stating X pain has slightly improved since the last visit. X is continuing with gentle activities and going to X. The exam of the left shoulder reveals X. There is a X. The range of motion is (active/passive) forward elevation X, external rotation with arm in abduction X, external rotation with arm in adduction X, and internal rotation to the buttock. Rotator cuff strength is X in X. Mild to moderate tenderness of the X. Speed's and Yergason's are X. X is noted. There is a painful arc of motion. The treatment plan included continued X. X is returned to full duty.

Physical therapy daily note dated X has the injured worker doing well but still has stiffness and tightness. X pain is rated X. Modalities used include moist heat for X minutes. X showed improved mobility at the X. X. Physical therapy daily note dated X has the injured worker doing well and felt good after the last time with only some soreness. X pain is rated X. Modality was X. X responded well to X. Most tightness noted at the X. X. X Progress report dated X has the injured worker with left shoulder pain. X is doing well at this time with no major complaints. The exam of the left shoulder reveals X. There is a X. The range of motion is (active/passive) forward elevation X, external rotation with arm in abduction X, external rotation with arm in adduction X, and internal rotation to the buttock. Rotator cuff strength is X in forward elevation X. Mild to moderate tenderness of the X. Speed's and Yergason's are X. X is noted. There is a painful arc of motion. The treatment plan included activities as tolerated and follow-up on an as needed basis.

The utilization review dated X denied the requested X. The reason for determination states the request exceeds guideline recommendations and there are no provider notes provided or MRI revealing pathology. All available clinical information has been reviewed. It is understood X suffered a shoulder injury. There are no clinic notes available or MRI results. The ODG Guidelines were reviewed. The guidelines have objective criteria which must be met prior to the approval of X. Typically X, this request cannot be

modified. Therefore, this request for X is not medically necessary.

The utilization review dated X denied the requested X. The reason for determination states that given the number of previously completed visits, functional improvements with the previous X is not medically necessary.

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

As per ODG, "X."

Also, as per ODG, "X".

In this case, this X sustained an industrial injury on X and is seeking authorization for X.

Overall, X presented on X with left shoulder pain. X was X. X went to X. X has been having pain since this X. The pain is intermittent and is dull, achy, and sharp. The exam of the left shoulder reveals X. There is a X. The range of motion is (active/passive) forward elevation X, external rotation with arm in abduction X, external rotation with arm in adduction X, and internal rotation to the buttock. Rotator cuff strength is X in forward X. Mild to moderate tenderness of the X. Speed's and Yergason's are X. X is noted. There is a X.

However, detailed documentation is not evident regarding the need for an initial X. The treatment plan by the requesting provider, X, M.D., requested X on the X exam. After the physical therapy initial evaluation on X, the therapist's treatment plan was for X. This exceeds the recommended guideline number of initial sessions per ODG. Moreover, the objective findings provided did not corroborate significant deficits that would not be able to be successfully treated with a prescribed X. There is no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines. Therefore, the request for X is not medically necessary.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE**
- AHRQ- 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**

TMF SCREENING CRITERIA MANUAL

**PEER REVIEWED NATIONALLY
ACCEPTED MEDICAL LITERATURE
(PROVIDE A DESCRIPTION)**

**OTHER EVIDENCE BASED,
SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A
DESCRIPTION)**