

I-Decisions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

(207) 338-1141 (phone)

(866) 676-7547 (fax)

Notice of Independent Review Decision

DATE OF REVIEW: 8/22/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Post-operative rotator cuff repair rehabilitation following surgery 01/23/07. Formal Physical Therapy was initiated 06/01/07 through 07/13/07. No additional visits were approved after the 13 visits ending 07/13/07.

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

On 08/22/07 case #xxxx was reviewed by an Orthopaedic Physical Therapist specializing in outpatient orthopaedic and post-operative injuries. The reviewer graduated with a Master's of Physical Therapy in May 2001, and has been practicing in Orthopaedics ever since. He has also obtained his Orthopaedic Clinical Specialist Certification (OCS) and is a Certified Manual Physical Therapist (CMPT) through the North American Institute of Orthopaedic Manual Therapy (NAIOMT).

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Operative report per Dr., MD dated 01/23/07.

MRI per dated 11/24/06.

Patient notes per Dr, MD dated: 01/26, 02/02, 02/09, 03/02, 04/06, and 06/25 all of 2007.

Shoulder Rotator Cuff Repair Rehabilitation Program.

Physical Therapy Evaluations dated: 06/01/07 and 07/13/07.

Medical Service reviews dated: 07/18/07 and 07/25/07.

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a xx year old female who fell xx/xx with injury to her right hip and shoulder. MRI ordered in November 2006 revealed a torn supraspinatus tendon, partial tears of the infraspinatus and subscapularis tendons, bursitis, distal clavicular osteophyte formation, and bursitis. Surgery 01/23/07 included: rotator cuff repair, distal clavicle resection, subacromial decompression, and arthroscopy. Physical Therapy HEP introduced 01/26/07, formal PT initiated 06/01/07-07/13/07. Corticosteroid injection 07/05/07.

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

Injured employee underwent major rotator cuff repair and arthroscopic surgery 01/23/07. Per included rehabilitation guidelines and physician orders, home therapy was initiated within the first week and no formal PT initiated for 8-12 weeks. Due to unspecified delays formal PT did not start until 06/01/07, over 18 weeks after surgery. Home PT was instructed per physician orders 01/26/07 and 04/06/07 although no PT records were included. Standard ODG Guidelines state approved post-operative rehabilitation for 24 visits over 14 weeks. This 14 week time period should begin at the onset of formal physical therapy. General Orthopaedic practice also indicates supervised rehabilitation for 8-12 weeks. This employee only received 13 visits over 6 weeks from a major reconstructive surgery. The injured employee was responding to formal therapy with objective and subjective gains. The standard 24 visits should be granted especially since formal therapy was initiated 6 weeks late. This 6 week delay could have contributed to the Adhesive Capsulitis complication. Adhesive Capsulitis should only extend physical therapy necessity if significant functional limitations remain and objective gains are continuing. The previous 2 reviewers state PT was carried out prior to surgery but no records indicate such treatment. As long as physician orders were written stating medical necessity for physical therapy, original treatment parameters should be followed. At least 11 treatments should be granted.

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 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)
- APTA GUIDE TO PHYSICAL THERAPY PRACTICE