

Clear Resolutions Inc.

An Independent Review Organization

7301 Ranch Rd 620 N, Suite 155-199

Austin, TX 78726

Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 24, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for aquatic therapy, five times a week for two months, left shoulder.

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

M.D., Board Certified Orthopedic Surgeon

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

Peer review, Dr., 11/2/07

Peer review, Dr., 11/29/07

MRI left shoulder, 6/29/05

ODG Guidelines

Operative report, Dr., 8/30/06

Office notes, Dr., 9/7/06, 9/28/06, 10/26/06, 11/27/06, 1/3/07, 3/1/07, 4/26/07

New patient evaluation, Dr., 9/11/07

Rehab requisition form, Dr., 9/27/07, 10/23/07

Physical therapy notes, 10/1/07 to 10/31/07

Office note, Dr., 10/23/07, 1/3/08

Letter of medical necessity, Dr. 11/2/07
Report, Dr., 11/27/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This xx year old male underwent left shoulder glenohumeral arthroscopy and subacromial decompression and open rotator cuff repair by Dr. on 08/30/06. The claimant had a large rotator cuff tear with retraction. Post op visits indicated that the claimant had physical therapy in October and November 2006. The records do not indicate how much therapy the claimant had at that time. Physician notes at four months post op documented elevation of 90 degrees, abduction 60 degrees, internal rotation to L3 and external rotation to 10 degrees. The supraspinatus was very weak with any type of elevation or abduction. Dr. recommended additional therapy but it was not approved.

On 03/01/07 elevation was about 150 degrees, abduction 75, external rotation 30 and internal rotation to L5. Rotator cuff strength was 4+/5 and the claimant had fairly good internal and external rotation strength. X-rays of the shoulder revealed 3 anchors in the bone without signs of interval change. Subacromial space was well maintained and the claimant was working on a home exercise program. On 04/26/07 elevation was to 120 degrees, abduction 70, internal rotation to the sacrum and external rotation 30. Rotator cuff strength was 4+/5 and the claimant was doing stretching and strengthening on his own. Dr. ordered a repeat MRI to evaluate the status of the rotator cuff.

The records lapse until 09/11/07 when the claimant began treating with Dr. for left shoulder pain, weakness, stiffness. On exam forward flexion was 110 degrees, abduction 100, external rotation with arm at side zero and internal rotation to the buttock. Passive range of motion was equal to active range of motion. Dr. indicated that the claimant did have a recent MRI but it was not available for review. The impression was rotator cuff lesion with possible rotator cuff tear and post op shoulder stiffness. He recommended hydrotherapy and a glenohumeral joint injection per radiology. Dr. prescribed aquatic therapy 3-5 times a weeks for 2 months. The claimant did complete 14 visits of aqua and land therapy.

At the follow up visit of 10/23/07 the shoulder movement had improved but the pain had not changed. Forward flexion was 160 degrees, abduction 130, external rotation with arm at side was 20 and internal rotation to L3. Dr. noted that the MRI from 2007 showed a full thickness tear of the supraspinatus, minimal retraction and no muscle atrophy. He recommended additional hydrotherapy for two months. This was denied on peer review. Dr. authored a letter of appeal dated 11/02/07 in which he emphasized that the aquatic therapy was medically necessary to regain mobility of the left shoulder. He felt that without therapy the claimant might require surgery in the form of a left shoulder capsular release. An office note of 01/03/08 with Dr. noted diffuse shoulder tenderness with exam findings unchanged from the visit of 10/23/07.

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

It is not clear to me as to the medical necessity for aquatic therapy five times a week for two months for the left shoulder. While I understand this medical record indicates this person had an 08/30/06 left shoulder open rotator cuff repair and postoperatively developed stiffness and limitations in function, and there was a repeat 2007 MRI documenting a full-thickness tear, the medical record also seems to indicate that this person has increasing function over time.

At the time of the 10/23/07 and 01/03/08 office visits of Dr., the claimant had quite reasonable motion to include forward flexion of 160 degrees and abduction 130 degrees with passive range of motion equalling active range of motion. It is not clear to me that this far after his surgery further aquatic therapy is going to be of benefit, and therefore I do not see the medical necessity for the requested aquatic therapy based on the medical record.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Shoulder: Physical Therapy.

Complete rupture of rotator cuff (ICD9 727.61; 727.6) Post-surgical treatment: 40 visits over 16 weeks

Adhesive capsulitis (IC9 726.0): Medical treatment: 16 visits over 8 weeks

The use of aquatic therapy is not specifically addressed in ODG for shoulder conditions.

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