

IRO Express Inc.

An Independent Review Organization

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DATE OF REVIEW: July 5, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

9 sessions of PT to include: Ultrasound, Manual therapy techniques, neuromuscular re-education, Manual electrical stimulation, therapeutic stimulation, therapeutic activities, and therapeutic exercises.

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

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)

Manual therapy techniques, neuromuscular re-education, Manual electrical stimulation, therapeutic stimulation, therapeutic activities, and therapeutic exercises are all medically necessary.

Ultrasound is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Office notes, 1/2/08, 01/08/08, 04/11/08, 05/07/08, 06/04/08

Work form, 1/2/08, 01/16/08, 06/06/08

X-ray right shoulder, 1/4/08

MRI, 1/15/08

Ortho note, 1/22/08, 01/23/08, 02/06/08, 02/27/08, 03/26/08

OR note, 2/4/08

HEALTH AND WC NETWORK CERTIFICATION & QA 7/17/2008

IRO Decision/Report Template- WC

Physical therapy notes, 3/25/08, 4/18/08, 4/24/08, 4/29/08, 5/2/08, 5/6/08, 5/9/08, 5/13/08, 05/07/08
Procedure notes, 4/23/08
Stellate ganglion block, C7, 4/28/08, 05/05/08
Pain management note, 4/30/08
Peer review, 5/16/08, 05/29/08
Letter, Dr. 5/20/08, 06/04/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male, right hand dominant, who sustained a right shoulder injury on xx/xx/xx while performing his duties. He underwent right shoulder arthroscopy with rotator cuff repair, subacromial decompression and labral debridement on 02/04/08. The records indicated he completed approximately eighteen therapy sessions following surgery. The claimant developed regional pain syndrome in the right upper extremity and received two stellate ganglion blocks on 04/28/08 and on 05/05/08 with noted improvement. The most recent therapy note on 05/07/08 noted flexion to 120 degrees , abduction to 109 degrees, external rotation to 50 degrees and internal rotation to 64 degrees . Strength remained slightly decreased in the shoulder. Continued therapy with passive and manual modalities was requested.

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

This gentleman sustained an injury xx/xx/xx during his course of employment. On 02/04/08, he underwent operative intervention consisting of right shoulder arthroscopy, rotator cuff repair, subacromial decompression, and labral debridement.

The notes reviewed showed that he completed 18 sessions of therapy following his surgery. His case, however, was compounded by development of complex regional pain syndrome (reflex sympathetic dystrophy). He received two stellate ganglion blocks. The most recent therapy note, 05/07/08, noted residual limited motion with flexion to 120 degrees, abduction to 109 degrees, and external rotation to 50 degrees. There was diminished strength.

The Reviewer's assessment is that this individual should have ongoing therapy. Postsurgical treatment usually allows 24 visits over 14 weeks. He has only received 18. He still has residual limited motion as well as weakness. It should be noted that not all people recover at the same pace. This gentleman still has objective diminished motion and weakness. The Reviewer would agree with additional therapy for manual therapeutic exercises and electrical stimulation. Both are approved by ODG guidelines. However, the use of ultrasound is not recommended.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates, Shoulder and Pain Chapters

Ultrasound, therapeutic: Not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active

therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. ([Robertson, 2001](#))

Manual therapy: Recommended for chronic pain if caused by musculoskeletal conditions

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Neuromuscular stimulation: Under study. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. Functional neuromuscular stimulation (also called electrical neuromuscular stimulation and EMG-triggered neuromuscular stimulation) attempts to replace stimuli from destroyed nerve pathways with computer-controlled sequential electrical stimulation of muscles to enable spinal-cord-injured or stroke patients to function independently, or at least maintain healthy muscle tone and strength. Also used to stimulate quadriceps muscles following major knee surgeries to maintain and enhance strength during rehabilitation. ([BlueCross BlueShield, 2005](#)) ([Aetna, 2005](#))

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)**