

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: JUNE 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity for physical therapy, three times a week for four weeks (12 sessions).

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

MD, 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)

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.

The reviewer finds that medical necessity does not exist for physical therapy, three times a week for four weeks (12 sessions).

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old male who sustained a right shoulder injury on xx/xx/xx when he slipped and fell. He attended six sessions of physical therapy for conservative management. He then underwent arthroscopic rotator cuff repair on 02/19/07 with suture anchors. He attended twenty-seven sessions of postoperative therapy. He apparently did well until he aggravated his shoulder in August of 2007 while lifting cement block at work. He reported increased pain with decreased motion and strength. Radiographs on 08/20/07 noted displacement of one of the humeral head anchors through the humeral head down towards the axilla exiting at the inferior boundary of the humeral head. On review of the operative report, Dr. indicated the claimant had very soft bone related to an extensive medical history including elevated INR, low platelets and liver disease. A CT study was completed on an unknown date and identified a

complete rotator cuff rupture. Operative intervention was delayed due to inability to obtain medical clearance through the work comp carrier. He continued to demonstrate decreased motion and strength. Serial radiographs indicated no further movement of the anchor which continued to abut the glenoid. The claimant underwent an open shoulder procedure on 01/15/08 where the anchor was noted to have traveled through the entire humeral head and was protruding four to five millimeters at the inferior humeral head. Visualization of the rotator cuff tear deemed it non repairable. The claimant attended twenty-nine sessions of postoperative physical therapy from 02/06/08 through 04/24/08. Therapy records documented progression from passive range of motion to active assistive and finally active motion with progressive strengthening. Steady progress was noted; however, the claimant continued to have difficulty with overhead activities. His job requirements included heavy repetitive overhead use. As of 04/21/08 physical examination demonstrated flexion to 150 degrees, abduction to 140 degrees, internal rotation to 65 degrees, external rotation to 61 degrees and strength at 4/5. Continued therapy was recommended.

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

The claimant underwent a number of surgical procedures including recent surgery on 01/15/08, at which time it was deemed that his rotator cuff was irreparable. He has had 29 sessions of therapy. The request for further physical therapy, three times a week for four weeks, is not indicated. He continues to have difficulty with overhead activities. Range of motion as of 04/21/08 revealed flexion to 150 degrees, abduction to 140 degrees, and internal rotation to 65 degrees. There is insufficient information provided to support that further therapy is indicated at this juncture.

Official Disability Guidelines Treatment in Worker's Comp 2008 Updates; Shoulder-Physical Therapy

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

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

Post-surgical treatment, open: 30 visits over 18 weeks

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

Post-surgical treatment: 24 visits over 14 weeks

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)