

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 27, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of physical therapy for right shoulder three times a week for four weeks.

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer reviews, Texas Insurance, 01/30/08, 02/15/08
Official Disability Guidelines Treatment in Worker's Comp 2008
Office notes, Dr. 04/28/06, 09/08/06, 10/05/07, 11/09/06, 12/07/06, 08/30/07, 01/04/07, 01/18/07, 02/15/07, 09/28/07, 12/05/07, 01/16/08, 02/06/08
"procedure pictures," 05/18/06
Physical therapy notes, 06/12/06 – 08/11/06, 10/02/07 - 12/03/07, 12/07/07-01/14/08, 01/15/08
Work hardening summary, 11/03/06, 11/17/06, 12/22/06, 01/05/07
Complete 2nd week, 11/10/06
Undated DC
Work conditioning summary, 12/15/06, 12/22/06, 01/05/07
Office note, Dr. 11/28/06
Report, Dr. 12/07/06

MRI right shoulder, 07/13/07
OR note, 09/20/07

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a right shoulder pain. She had a right shoulder decompression and rotator cuff repair in 05/06. This was followed by apparently limited therapy and ongoing pain. She did have work hardening for six weeks with the resultant capability to work light duty. Her right shoulder pain and weakness continued and an MRI was obtained on 07/13/07 that showed the previous surgery. There was a moderate subacromial spur; bursal surface tear of the supraspinatus with suggestion of perforation; and moderate supraspinatus and infraspinatus tendinosis as well as mild subscapularis tendinosis.

On 08/30/07 Dr. once again saw the claimant for right shoulder pain. He noted that she was allowed to work without restrictions but was no longer working. On examination there was a mild impingement sign, weakness with empty can and some tenderness at the cuff insertion. Full duty was recommended. On 09/20/07 the claimant underwent revision arthroscopic acromioplasty and mini open repair of rotator cuff and biceps tenodesis. Dr. saw the claimant on 09/28/07 and noted that she was doing well with her shoulder but had increased wrist pain. On examination there was good shoulder flexion and extension. Therapy was recommended. She attended therapy 10/02/07 to 12/03/07 for 10 visits. On 12/05/07 Dr. evaluated the claimant and found full passive motion. Active forward flexion was 130 degrees with pain and some pain over the DeQuervain's. Additional therapy, aquatics and off work were recommended. Therapy was attended 12/07/07-01/14/08 for at least an additional 10 sessions. Flexion on 01/14 was to 163 degrees, abduction 143 degrees, internal rotation 60 degrees and external rotation 66 degrees passive. Active flexion was 115 degrees, abduction 101 degrees, internal rotation to L2 and external rotation to 43 degrees. Motion was slightly improved from 12/03, strength was essentially unchanged.

On 01/16/08 Dr. again saw the claimant for pain in the right shoulder and wrist. Passive motion was flexion 163 degrees and abduction 145 degrees. There was reported tenderness and pain with motion, positive Finkelstein and pain over the first dorsal compartment. Additional therapy for 12 sessions was recommended. On 02/06/08 Dr. indicated that therapy had been denied. Forward flexion was to 165 degrees, abduction 145 degrees with 170 degrees and 180 degrees respectively on the left with pain. There was a positive Finkelstein. Additional therapy was recommended.

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

The reviewer finds that additional physical therapy for the right shoulder three times a week for four weeks is not medically necessary. The patient has received 45 sessions and has near normal motion documented on physical examination 02/06/08. Though the treating physician reports a lack of significant strength and motion, the actual numbers detailed on physical examination are quite functional and near normal.

Official Disability Guidelines Treatment in Worker's Comp 2008

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

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)