



Notice of Independent Review Decision

DATE OF REVIEW: 10/20/08

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for 12 sessions of occupational therapy to the right shoulder.

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

Texas licensed Occupational Medicine Physician.

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 previously denied request for 12 sessions of occupational therapy to the right shoulder.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Medical Necessity Letter dated 10/10/08.
- Notice to CompPartners of Case Assignment dated 10/7/08.

- Confirmation of Receipt of Request for a Review by an Independent Review Organization dated 10/6/08.
- Referral Form dated 10/6/08.
- Request for Review by an Independent Review Organization dated 9/30/08.
- Determination Notification Letter dated 9/24/08, 8/26/08.
- Follow-up Report dated 9/16/08, 5/13/08, 1/22/08, 11/27/07.
- Examination Report dated 8/6/08, 6/27/08, 6/6/08.
- Right Shoulder MRI Report dated 3/30/08.
- New Patient Consultation Report dated 11/5/07.
- First Consultation Report dated 11/5/07.
- Right Shoulder Computerized Tomography Report dated 10/24/07.
- Treatment History (unspecified date).

No Guidelines were provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury:

Mechanism of Injury: Slip and fall injury

Diagnosis: Right shoulder impingement syndrome.

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

The claimant is a female involved in a work related injury on xx/xx/xx. Limited details about the injury were available for review, but the claimant apparently fell, landing on her right shoulder. The claimant was treated with physical therapy modalities for an extended period of time, but this did not help. The claimant was seen by the orthopedist, Dr. in 11/07, who noted that “The patient has failed to respond to PT and to several medications. She has significant decreased abduction and range of motion of the right shoulder due to pain symptoms.” The claimant had a CT scan of the right shoulder done on 10/24/07, that did not show significant pathology, but due to persistence of symptoms, an MRI of the right shoulder was eventually done on 3/30/08. The scan was interpreted as showing a complete thickness tear of the distal supraspinatus tendon. A request was made for surgical correction of the rotator cuff tear, and this request was authorized by the carrier. There was a note from orthopedist, Dr. from 6/27/08, stating that the claimant’s “Pain has been helped with the therapy. She wants to defer surgery.” On 8/6/08, the claimant was again “Doing better and the therapy is helping.” Yet in Dr. ’s note from 9/16/08, he noted “Patient continues with pain to right shoulder. Patient taking Darvocet to help decrease pain symptoms. States feels a stabbing sensation to right shoulder. Physical therapy has improved range of motion.” Consequently, a request was made for continuation of occupational therapy services times 12 sessions, a request which included modalities 97110, 97124, 97035 and 97014, which is respectively, therapeutic exercises, massage therapy, ultrasound and electrical stimulation. There are no further notes submitted for review. This request for additional therapy services has been denied on two

separate occasions, by two different physician reviewers. The request has now been submitted to IRO for another assessment. The available clinical information in this case does not support the medical appropriateness of further therapy to the right shoulder. The claimant has a torn rotator cuff, which, given persistence of pain and dysfunction merits surgical correction. A request for rotator cuff repair surgery has been previously granted, but the claimant wished to wait on surgical intervention as “therapy was helping.” But this statement is not corroborated by the objective and subjective clinical evidence. The claimant has continued pain, despite extensive therapy and despite extensive passive treatment modalities such as ultrasound, massage and electrical stimulation. No data was provided to support that there was any functional improvement or objective improvement in the claimant’s condition; rather, we note ongoing pain complaints and ongoing need for narcotic analgesics. A comment was also made that the claimant has had an improvement in shoulder range of motion, yet Dr. ’s note from 9/16/08 clearly indicates “No improvement of ROM (from last exam).” In addition, she continued to work on light duty, her right shoulder condition precluding her ability to engage in full duty work as a cook. Thus the assertion made that the therapy is helping her with either or both, range of motion and pain, is not supported by the available objective and subjective clinical data submitted for review. Consequently, this reviewer is unable to recommend additional therapy for this claimant at this time. Data does indicate that the claimant should be able to be engaged in an independent home exercise program (no data indicating compliance with such a program is provided for review, however), emphasizing stretching and strengthening, as would be instructed in an occupational and physical therapy program. Given the many sessions that this claimant has had thus far, one would expect that the claimant would be well versed in such a home exercise program. No data is submitted to indicate that the claimant is an outlier to clinical guidelines, or that she would not be able to perform a home exercise program. The ODG state: "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. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Medical treatment: 10 visits over 8 weeks" Therefore, determination is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- AHCPH – 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.

X ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
(web based Guidelines 6th Edition, 2008, Integrated Treatment/Disability Duration Guidelines. Shoulder (Acute & Chronic).

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).