

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills,
CA 90211

Ph: (323)556-0555 Fx:
(323)556-0556

DATE OF REVIEW: October 2, 2008

IRO CASE #:

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

This case was reviewed by a Pain Management doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Appeal physical therapy, 3 X 4 Right Shoulder

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be: Upheld (Agree)

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx . A June 26, 2008 report rendered a non-certification for the above-captioned request. The report states that the patient had a closed dislocation of the shoulder and that the Official Disability Guideline supports up to 12 sessions of physical therapy for this diagnosis. The patient had already completed 25 sessions of therapy for the injury.

A July 7, 2008 letter from the patient was submitted for review. The letter states that she disagrees with a denial of continued physical therapy sessions and she has seen excellent progress, largely because she has not missed a session and has worked hard to get function back. In addition to the original injury which occurred on xx/xx/xx, she had five subsequent dislocations until well into physical therapy. Without additional therapy, she does not believe that she will get full function back and may be subjected to additional dislocations. She stated that she does not want to have a permanent disability. She listed basic functions that she is not able to perform or is unable to perform without pain. Several work duties were listed in addition to activities of daily living. She stated that until she is able to make backward and rotation movements with the shoulder, she is not back to normal. She stated that she was able to avoid surgery through physical therapy.

The case was again reviewed on July 11, 2008 and another non-certification was rendered. This report states that radiographs had revealed reduced glenohumeral joint with no fracture/dislocation. The patient had undergone 25 physical therapy visits. The reviewer stated that the records do not reflect the clinical indications for ongoing formal physical therapy versus a home exercise program.

The request was again reviewed on August 22, 2008 and was again non-certified. The reviewer commented that the claimant has completed 25 visits of physical therapy to date and the records do not reflect clinical indications for ongoing formal physical therapy versus a home exercise program.

The records include a June 27, 2008 chart note which states that the patient is improving with physical therapy and continues to have difficulties with activities of daily living. Examination findings included no apprehension with range of motion, forward elevation to 160°, abduction external rotation 80° with pain, internal rotation to T12 compared to T6 on her left shoulder, painful impingement testing, and 5/5 deltoid and cuff strength.

She underwent a designated doctor evaluation on July 10, 2008. The report outlines the results of a March 12, 2008 MRI with the following impression: Acute labral/ligamentous injury (Bankart lesion) of the inferior glenoid with associated glenoid fracture, likely related to history of recent dislocation. Mild to moderate glenohumeral joint effusion/hemorrhage. Possible additional tearing involving the superior labrum posterior to the biceps anchor. Mild acromioclavicular joint arthropathy. Mild supraspinatus tendinopathy without evidence for rotator cuff tear. A CT scan performed on March 31, 2008 reportedly revealed anterior-inferior bony glenoid fractures minimally displaced and mild degenerative changes at the acromioclavicular joint. The patient stated that she has returned to work on full duty since the accident. Examination findings included symmetric upper extremity deep tendon reflexes, no tenderness or spasm about the right shoulder, several negative orthopedic tests, right shoulder observed range-of-motion decreased with full effort on external rotation to the level of the sacrum only, no atrophy noted, and normal motor strength in the deltoids, biceps brachii, and triceps brachii bilaterally. The physician opined that the patient has not reached MMI at this time, but is expected to on or about October 10, 2008. The recommendation was made that the patient continue with physical therapy as recommended by the treating physician.

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

On June 27, 2008, the patient was found to have 160° of forward elevation and internal rotation to the level of T12. She has been found to have normal motor strength on two evaluations as outlined above. On July 10, 2008, the physician stated that the patient had returned to work on full duty. It is reasonable that the patient can attain additional range-of-motion in an independent home exercise program. She has undergone 25 physical therapy visits, which exceeds the Official Disability Guidelines recommendation of 12 visits. Therefore, my determination is to uphold the previous non-certification of physical therapy, 3 X 4 Right Shoulder.

The IRO's decision is consistent with the following guidelines:

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

X 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

Official Disability Guidelines (2008): Shoulder Chapter

Physical therapy

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Use of a home pulley system for stretching and strengthening should be recommended. (Thomas, 2001) For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. The mainstays of treatment for instability of the glenohumeral joint are modification of physical activity and an aggressive strengthening program. Osteoarthritis of the glenohumeral joint usually responds to analgesics and injections into the glenohumeral joint. However, aggressive physical therapy can actually exacerbate this condition because of a high incidence of joint incongruity. (Burbank, 2008) (Burbank2, 2008)

Impingement syndrome: For impingement syndrome significant results were found in pain reduction and isodynamic strength. (Bang, 2000) (Verhagen-Cochrane, 2004) (Michener, 2004) Self-training may be as effective as physical therapist-supervised rehabilitation of the shoulder in post-surgical treatment of patients treated with arthroscopic subacromial decompression. (Anderson, 1999) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone. Laser therapy is an effective single intervention when compared with placebo treatments, but adding laser treatment to therapeutic exercise did not improve treatment efficacy. The limited data available do not support the use of ultrasound as an effective treatment for reducing pain or functional loss. Two studies evaluating the effectiveness of acupuncture produced equivocal results. (Sauers, 2005)

Rotator cuff: There is poor data from non-controlled open studies favouring conservative interventions for rotator cuff tears, but this still needs to be proved. Considering these interventions are less invasive and less expensive than the surgical approach, they could be the first choice for the rotator cuff tears, until we have better and more reliable results from clinical trials. (Ejnisman-Cochrane, 2004)

Adhesive capsulitis: For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. (Carette, 2003) Physical therapy following arthrographic joint distension for adhesive capsulitis provided no additional benefits in terms of pain, function, or quality of life but resulted in sustained greater active range of shoulder movement and participant-perceived improvement up to 6 months. (Buchbinder, 2007) Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral.

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

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

Dislocation of shoulder (ICD9 831):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

Acromioclavicular joint dislocation (ICD9 831.04):

AC separation, type III+: 8 visits over 8 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)

Medical treatment: 9 visits over 8 weeks

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

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Fracture of clavicle (ICD9 810):

8 visits over 10 weeks

Fracture of humerus (ICD9 812):

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks