

# US Resolutions Inc.

An Independent Review Organization

71 Court Street

Belfast, Maine 04915

## Notice of Independent Review Decision

**DATE OF REVIEW: OCTOBER 20, 2008**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Medical necessity for functional restoration program, right shoulder five times a week for two weeks (10 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 functional restoration program, right shoulder five times a week for two weeks (10 sessions).

### **PATIENT CLINICAL HISTORY (SUMMARY):**

This claimant is a male who had 3 large watermelons weighing about 100 pounds fall out of a crate from 8 feet on xx/xx/xx which he attempted to catch with his right arm. In 11/06 he underwent an open rotator cuff repair for a full thickness supraspinatus tear. A new MRI found that the cuff repair had failed. On 04/30/08 he underwent an attempted reconstruction, subacromial decompression and debridement of the rotator cuff tear. However complete retraction of the rotator cuff was found with no ability to repair the rotator cuff defect. A functional capacity evaluation on 07/15/08 noted the claimant's job to fall within the heavy level of demand. His testing determined that he was functioning at the below sedentary level. A pain management or functional restoration program was recommended. As of 08/07/08 he had attended 2 visits of the PRIDE program. He was putting good effort into things with assisted movements up to 120 degrees abduction and 80 degrees flexion. He still had a significant problem with internal rotation as was his

active motion which was essentially restricted to 30-45 degrees in flexion/abduction. He reported numbness in the arm mainly along the medial aspect of the forearm and hand, but extending into the medial 3-4 fingers, not merely the ulnar distribution. He was very sensitive in the cubital tunnel but also had substantial tenderness in the shoulder area, including the axillary region. The possibility of ulnar nerve injury, plexopathy or cervical radiculopathy could not be ruled out. There was marked weakness in his hand including his intrinsics, which also suggested a lesion was present. Continuation of his slow progress in the PRIDE program and EMG/NCV studies were recommended.

A review of the progress on 08/21/08 noted the claimant's attendance in 10 visits. He was significantly more physically active, but had fewer flare-ups. No longer ceases physical activity with flare-ups and successfully completed taper from narcotic medication. He had moderately improved motion, 30 percent of average strength on arm weights, poor grasping and was unable to reach overhead. He reported functional improvement at home with improved ability to put on pullover shirt (modified method), and to help store dishes in cabinets in kitchen, reports reaching behind back better, but still having difficulty gaining overhead reaching range. Grip strength was slightly better. He gave good effort and was able to push and pull a grocery cart with less pain. An additional 10 visits were recommended.

On 09/05/08 Dr. saw the claimant for an electrodiagnostic consultation reporting progressive numbness in the right hand and lower forearm since the xxxx injury with pain approximating the C6 nerve distribution, but not entirely. He denied any weakness except at the shoulder girdle and had no frank numbness but more of a paresthesia. The examination noted significant deltoid atrophy with a lateral well healed surgical scar. There was upper extremity weakness throughout the shoulder girdle but no weakness at the elbow, wrist or hand. The electrodiagnostic studies showed evidence of moderately severe carpal tunnel syndrome without evidence of active denervation. The electromyographic findings in the right deltoid were compatible with postoperative changes and disuse atrophy. There was no evidence of brachial plexopathy or cervical radiculopathy affecting the right upper extremity. The request for continuation of the functional restoration program was denied on two reviews.

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

Functional restoration program is not medically indicated and appropriate in this male who has had two surgeries about his rotator cuff most recently on 04/08 for which a repair was not able to be performed. He has had functional capacity evaluation on 07/15/08 noting his effort was below sedentary duty and did not meet his lifting and carrying requirement for his job which is described as heavy. One would expect given these findings that he would not be able to return back to the job given this shoulder problem as the functional unit is not attached with the tendon to restore strength and motion. It is unclear if a functional restoration program will have benefit regarding this right shoulder with a completely torn rotator cuff. This is unnecessary and not needed based upon medical records. The reviewer finds that medical necessity does not exist for functional restoration program, right shoulder five times a week for two weeks (10 sessions).

Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, (i.e. Pain – Functional Restoration Programs)

**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)