

US Decisions, Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: JANUARY 5, 2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Occupational Therapy for Right Shoulder x 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 Occupational Therapy for Right Shoulder x 12 Sessions.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Review, Dr. , 12/09/08

Review, Dr. 12/12/08

ODG Guidelines and Treatment Guidelines

Office note, Dr. , 12/03/08
Prescription for physical therapy, 12/03/08
Occupational therapy note, 12/05/08
Request for physical therapy, 12/08/08
Notes, , 12/09/08, 12/12/08
Request for occupational therapy, 12/10/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year-old, right hand dominant male who was injured via an unknown mechanism on xx/xx/xx. Dr. evaluated the claimant on 12/03/08 at which time it was noted that an injection had markedly improved his symptoms. It was noted that strength was better, but reduced though and he was thought to have primary impingement. On examination there was less pain and tenderness in the shoulder, but better flexibility, motion, strength and power. Primary impingement of the shoulder joint blocking the subacromial bursa and a labrum lesion were diagnosed. Continuation of exercises with therapy and his activity program was recommended.

A therapy note on 12/05/08 noted aching and soreness of the shoulder with occasional numbness of his hands. He reported 80 percent improvement of his condition, compliance with therapy and continued improvement. Active motion was: flexion 172 degrees, abduction 145 degrees, external rotation 72 degrees, internal rotation 57 degrees, extension 55 degrees and adduction 42 degrees. Strength was 4+/5. Passive motion was within normal limits. Additional occupational therapy was recommended. The request was denied twice on peer review and is currently under dispute.

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

Additional therapy for this claimant's right shoulder cannot be justified based on the information provided for review. The claimant has already received physical therapy for a diagnosis of right shoulder impingement. ODG guidelines suggest treatment with up to 10 visits over an eight week period. The request exceeds the recommendations in the guidelines. The reviewer finds that medical necessity does not exist for Occupational Therapy for Right Shoulder x 12 Sessions.

Official Disability Guidelines Treatment in Worker's Comp 2009 Updates, (i.e. Shoulder-Physical Therapy)

Rotator cuff syndrome/Impingement syndrome:
Medical treatment: 10 visits over 8 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)**