



Notice of Independent Review Decision

**DATE OF REVIEW:** 6/9/09

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for twelve sessions of physical therapy to the left shoulder at Beaumont Bone and Joint.

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

Texas licensed Family Practice 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 twelve sessions of physical therapy to the left shoulder at Beaumont Bone and Joint.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- **Prospective Review (M2) Response Sheet dated 6/1/09.**
- **Texas Department of Insurance Fax Cover Sheet dated 5/29/09.**

- Notice to CompPartners, Inc. of Case Assignment Sheet dated 5/29/09.
- Confirmation of Receipt of a Request for a Review by an Independent Review Organization Sheet dated 5/28/09.
- Pre-Authorization Decision and Rationale Sheet dated 5/22/09, 5/14/09
- Notice of Assignment of Independent Review Organization Sheet dated 5/29/09.
- Authorization Decision Sheet dated 5/22/09, 5/14/09.
- Pre-Authorization Request Form dated 5/21/09, 5/18/09, 5/11/09.
- Patient Progress Summary Sheet dated 5/18/09.
- Treatment Request Sheet dated 5/18/09, 5/11/09, 4/22/09, 4/15/09, 4/14/09, 3/23/09.
- History of Present Illness Summary Report dated 5/8/09, 4/15/09, 3/18/09, 2/11/09, 1/14/09, 12/31/08, 12/3/08, 11/12/08.
- Precaution/Instruction Sheet dated 5/8/09.
- Texas Workers' Compensation Work Status Report dated 5/8/09.
- Preoperative Report dated 4/7/09.
- Patient Medical History Summary dated 2/18/09.
- Treatment Session Summary Note dated 11/19/08.
- MRI of Left Shoulder Report dated 1/7/09.
- Physical/Occupational Therapy Rehab Assessment Report (unspecified date).
- Workers' Compensation Non-Network IRO Decision Description Note (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: A cabinet tipped over and she tried to catch it.

Diagnosis: Left shoulder adhesive capsulitis and status post manipulation under anesthesia.

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

This is a female who was injured on xx/xx/xxxx. She was at work when a cabinet started to tip over and she tried to catch it. Her diagnosis was left shoulder adhesive capsulitis, and status post manipulation under anesthesia (MUA). According to the information submitted for review, the patient had 57 physical therapy visits total; 26 of which were after her left shoulder manipulation under anesthesia. Her treating physician recommended "continuous" physical therapy; however, additional treatment beyond the

26 post-MUA visits was denied twice in peer review. After reviewing the physical therapy notes between April 2009 and May 2009, the reviewer found that little improvement was made with 19 visits. Comparing a range of motion from April 8, 2009 on visit 1 to the range of motion on May 18, 2009 on visit 19, forward flexion improved only by 10 degrees, abduction improved by 2 degrees, external rotation was not able to be determined due to the illegible writing, and internal rotation remained the same. The patient was treated with a continuous passive motion machine after her manipulation under anesthesia as well. She received a cortisone injection on May 8, 2009; however, it is unknown what her response was. In fact, on May 8, 2009, the patient stated that she felt her recent physical therapy visit actually made her worse due to aggressive manipulation. Her physical examination revealed that she lacked 10 degrees of flexion, abduction was 110 degrees, internal rotation was to L4, and she “was still lacking significant external rotation.” He felt that continued therapy for a prolonged period of time was indicated. The Official Disability Guidelines allow for 24 visits of therapy for diagnosis of adhesive capsulitis. The patient completed 57 visits so far. She should be more than capable of continuing with an independent home program at this point. The general course of adhesive capsulitis in the chronic phase, is for a gradual increase in range of motion with spontaneous recovery. Based on the clinical information provided, continuing the therapy does not seem medically necessary and is not consistent with guideline recommendations. This reviewer concurs with the previous two reviewers and recommends that the adverse determination for additional therapy be upheld. The patient should be able to continue with an independent strengthening and stretching program at home.

**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.
- 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.  
The Official Disability Guidelines (ODG), Web Based Version, 7th Edition, 2009, Shoulder PT.

- 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).