

# US Decisions Inc.

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Sep/23/2009

**IRO CASE #:**

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

12 Physical Therapy Visits, 97110, 97140

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

M.D., 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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

ODG Guidelines and Treatment Guidelines

Review, Dr. 08/25/09

Review, Dr. 08/31/09

Prescriptions, 03/13/09, 03/18/09, 06/01/09, 07/22/09, 08/14/09

Physical therapy initial evaluation, 03/25/09

MRI left shoulder, 03/31/09

X-rays left shoulder, 04/02/09

Office notes, Dr., 04/09/09

Operative report, 05/22/09

PT re-evaluations, 06/03/09, 07/03/09, 07/24/09

Office notes, Dr., 07/22/09, 08/14/09

PT progress report, 08/12/09

PT note, 08/27/09

CT Brain, 03/31/09

**PATIENT CLINICAL HISTORY SUMMARY**

This claimant is a male, right hand dominant who sustained a fracture dislocation of the left shoulder on xx/xx/xx when he tripped and fell onto his left shoulder. On 05/22/09 he

underwent a manipulation under anesthesia of the left shoulder and left shoulder arthroscopy with debridement/lysis of adhesions and bursectomy. He began postoperative therapy. Dr. saw the claimant on 07/22/09 for complaints of left shoulder pain and stiffness. Shoulder motion was: elevation 80 degrees active, 100 degrees passive and external rotation 5 degrees passively. Supraspinatus, infraspinatus and subscapularis strength were 4/5. X-rays of the left shoulder, date not given were noted to show a successful reduction of the anterior humeral dislocation with irregularity of the greater tuberosity of the humerus suggesting a Hills-Sachs type fracture of the proximal humerus. Left frozen shoulder and left anterior shoulder dislocation were diagnosed.

The claimant continued in therapy. The most recent therapy note is dated 08/12/09 at which time it was noted that he had attended 19 of the 24 approved visits and was making steady progress. He had ongoing severe limitation with reaching overhead and out to the side. Left shoulder active motion was: flexion 88 degrees, extension 56 degrees, abduction 60 degrees, horizontal abduction 85 degrees, horizontal adduction 23 degrees, internal rotation 61 degrees and external rotation 21 degrees. Passive motion was: flexion 138 degrees, extension 55 degrees, abduction 145 degrees, horizontal abduction 85 degrees, horizontal adduction 25 degrees, internal rotation 64 degrees and external rotation 24 degrees. Strength was: flexion, abduction and external rotation 2+/5; extension, horizontal adduction 3/5; horizontal abduction 2/5, and internal rotation 3+/5. Additional therapy was recommended. Dr. re-evaluated the claimant on 08/14/09 noting ongoing problems with lifting, pulling and reaching overhead. He reported pain radiating into the left arm, forearm and wrist. He was taking pain medication and attending therapy without changes in motion. Normal findings were noted on examination. X-rays of the left shoulder showed all bone joint and soft tissues appeared normal. There was no evidence of tumor, infection, fracture, subluxation or degeneration. There was a calcific lining of the dorsal capsule of the left shoulder. The fracture was healed in good position. Additional therapy was denied on reviews of 08/25/09 and 08/31/09. The therapist authored a note on 08/27/09 stating that therapy postoperatively had resulted in improved motion and function and that further therapy was necessary to increase mobility and function.

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

It would appear that at least 22 of 24 physical therapy visits were completed in this case. The postsurgical treatment of adhesive capsulitis under the Official Disability Guidelines would allow for 24 visits over 14 weeks. It has now been four months since the procedure in question. The additional requested therapy would far exceed the guidelines. The reviewer is therefore unable to recommend the proposed additional therapy as medically necessary under the guidelines. The reviewer finds that medical necessity does not exist for 12 Physical Therapy Visits, 97110, 97140.

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

Adhesive capsulitis

Post-surgical treatment: 24 visits over 14 weeks

Dislocation of shoulder

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

Fracture of humerus

Post-surgical treatment: 24 visits over 14 weeks

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

- ACOEM-AMERICA 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)