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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 02/08/2010 **AMENDED 02-09-2010**

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 (Board Certified), 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

Nine sessions of physical rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 12-16-09 PT Progress Note from Dr.
- o 12-18-09 Fax cover request for 9 sessions of physical rehab from Dr.
- o 12-24-09 Initial Adverse Determination letter and Review
- o 12-24-09 Adverse Determination letter
- o 01-06-10 Request for Reconsideration from Dr.
- o 01-11-10 Adverse Determination letter and Review for reconsideration
- o 01-28-10 Request for IRO from the Claimant
- o 01-28-10 Confirmation of Receipt of Request for IRO from TDI
- o 02-01-10 Letter with appeal rationale from Dr.
- o 02-01-10 Notice of Case Assignment of IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a male assembler who sustained an industrial injury to the left shoulder on xx/xx/xx when he went to pull himself up. He reported a loud pop at the shoulder. X-rays were taken and showed well maintained subacromial space, no fractures and normal alignment with some AC joint arthropathy. MRI was performed on August 13, 2009 and revealed partial thickness bursal tear of the supraspinatus tendon at its insertion, AC joint arthropathy, and a type 2 acromion.

The patient was reassessed in PT on December 16, 2009. He reports constant left shoulder pain of 4-8/10 intensity aggravated by reaching, lifting, pushing and pulling activities. There is tenderness at the AC joint. Flexion is to 150 degrees, abduction to 140 degrees, extension to 25 degrees and internal and external rotation to 60 degrees. Shoulder strength is 4-5 with flexion,

abduction and internal/external rotation. External rotation strength is 4+/5. He has reportedly improved with left shoulder active ROM and strength. Remaining goals are to increase shoulder strength and ROM, decrease shoulder pain, and improve tolerance with activities. Additional active and passive therapy is recommended.

Request for nine additional sessions of physical rehabilitation to the left shoulder was considered in review on December 24, 2009 with recommendation for non-certification. The patient has completed 20 certified sessions of PT to date. A peer discussion was attempted but not realized. The patient is reporting constant left shoulder pain of 4-8/10 and described as sharp. Examination showed guarded motion and tenderness over the left AC joint, deltoid and trapezius. Flexion was to 150 degrees, abduction to 140 degrees, extension to 25 degrees and internal and external rotation to 60 degrees. MRI was mentioned but the report was not submitted. After 20 PT visits the patient should be progressed to HEP. Additionally, there are no progress reports submitted documenting the patient's compliance and response to treatment. The therapy goals that delineate the endpoint of care have also not been clarified. Exceptional factors have not been noted that would substantiate a medical necessity for visits exceeding guidelines.

The provider responded with a letter for reconsideration dated January 6, 2010. The patient has improved with therapy but has not reached a plateau. He can still demonstrate improvements that will allow him to perform his mechanic duties. The level of care that is required to insure maximum progression is significantly beyond the scope of a home based exercise program.

Request for reconsideration, nine sessions additional of physical rehabilitation to the left shoulder was considered in review on January 11, 2010 with recommendation for non-certification. The patient is more than 6 months post injury and continues to have functional deficits. He has attended 20 sessions of PT without documented progressive objective improvement. The records contain minimal clinical documentation regarding a recent objective assessment of improvement, especially from a functional standpoint. Given the abnormal MRI findings, additional PT may not significantly improve the patient's functionality. The provider indicated in peer discussion that he would review the chart again including the PT notes and call back for further discussion before the deadline. A call was not received.

The provider has made a final appeal on February 1, 2010. The patient has not yet reached his pre-injury functional level. He is expected to demonstrate further improvements in all parameters with physical rehabilitation.

Request was made from an IRO.

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

The patient is an assembler who appears to have sprained his left shoulder when pulling himself up. Imaging shows a partial thickness bursal tear of the supraspinatus tendon at its insertion and some pre-existing AC joint arthropathy. He has completed 20 sessions of physical therapy. At reassessment six months post-injury, he reports constant left shoulder pain of 4-8/10 intensity aggravated by reaching, lifting, pushing and pulling activities. There is tenderness at the AC joint. Flexion is to 150 degrees, abduction to 140 degrees, extension to 25 degrees and internal and external rotation to 60 degrees. Shoulder strength is 4-/5 with flexion, abduction and internal/external rotation. External rotation strength is 4+/5. He has reportedly improved with left shoulder active ROM and strength. Remaining goals are to increase shoulder strength and ROM, decrease shoulder pain, and improve tolerance with activities. Additional active and passive therapy of nine visits is requested.

According to the first line review, MRI was mentioned but the report was not submitted. After 20 PT visits the patient should be progressed to HEP. Additionally, there are no progress reports submitted documenting the patient's compliance and response to treatment. The therapy goals that delineate the endpoint of care have also not been clarified. Exceptional factors have not been noted that would substantiate a medical necessity for visits exceeding guidelines.

According to the second line reviewer, the patient is more than 6 months post injury and continues to have functional deficits. He has attended 20 sessions of PT without documented progressive objective improvement. The records contain minimal clinical documentation regarding a recent objective assessment of improvement, especially from a functional standpoint. Given the abnormal MRI findings, additional PT may not significantly improve the patient's functionality. The provider indicated in peer discussion that he would review the chart again including the PT notes and call back for further discussion before the deadline. A call was not received.

The patient has a partial thickness bursal tear of the supraspinatus tendon at its insertion with well maintained subacromial space per imaging. He has reportedly improved with therapy. The patient is relatively young and there is a good chance his bursal tear will heal. Per references, the incidence of full-thickness rotator cuff tears increases with age; however, tears are not always painful. Tears can be managed successfully with nonsurgical treatment in 50% of patients.

ODG supports 10 visits of PT over 8 weeks for the patient's diagnosis. The deficits noted are in the mild range. The patient does not have indication of complicating factors such as impingement and after 20 sessions of formal PT should be able to complete his rehabilitation with a HEP. The clinical findings do not indicate exceptional factors that would substantiate a medical necessity for visits exceeding guidelines.

Therefore, recommendation is to agree with the previous non-certification for nine sessions of physical rehabilitation.

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
- 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

The Official Disability Guidelines, Shoulder Chapter (01-30-2010) 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. 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.

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

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

American Academy of Orthopedic Surgeons, online at <http://orthoinfo.aaos.org/topic.cfm?topic=a00406> "Rotator Cuff Tears and Treatment Options:" The incidence of full-thickness rotator cuff tears increases with age; however, tears are not always painful. Tears can be managed successfully with nonsurgical treatment in 50% of patients. Pain and range of motion will improve with nonsurgical management, but strength will not. Large tears, significant weakness, and an acute traumatic event are possible causes of poor outcome from nonsurgical management.