



Notice of Independent Review Decision
IRO REVIEWER REPORT

DATE OF REVIEW: 6/15/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for physical therapy (PT) 3 times a week for 4 weeks to the left shoulder - CPT codes 97110 and G0283.

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

Texas licensed orthopedic surgeon

REVIEW OUTCOME:

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

- | | |
|---|----------------------------------|
| <input checked="" type="checkbox"/> Upheld | (Agree) |
| <input type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> 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 physical therapy 3 times a week for 4 weeks to the left shoulder - CPT codes 97110 and G0283.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY (SUMMARY):

Age:

Gender: Female

Date of Injury: xx/xx/xx

Mechanism of Injury: Threw a trash bag half full of books in a trash bin.

Diagnoses: Tear of the rotator cuff, left shoulder; sprain and degenerative joint disease, left shoulder.

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

The claimant is a female who sustained a left shoulder injury on xx/xx/xx when she threw a trash bag, half full of books into a trash bin. The diagnoses were tear of the rotator cuff, left shoulder; sprain and degenerative joint disease, left

shoulder. On 9/14/09 Dr. performed a left Mumford procedure, lateral resection of the clavicle, left acromioplasty, excision left subacromial bursa, and repair of the rotator cuff. PT treatment notes from 11/03/09 to 4/5/10 were provided. Dr.'s office note of 3/24/10 indicated that the claimant had reached maximum medical improvement and was released to light duty with restrictions of no lifting over 10 pounds for 4 months. On 5/11/10 Dr. noted that the claimant was not back to work because she was unable to lift 50 pounds. A prescription was given for additional PT to increase range of motion and strength. A 5/20/10 PT re-evaluation noted complaints of intermittent left arm pain and pain going to the left side of the neck. Active flexion was 125 degrees, abduction was 160 degrees, internal rotation was within normal limits and external rotation was 90 degrees. Strength was 3+/5 in flexion and abduction and 4/5 in external rotation and internal rotation. The claimant had pain with all active movement of the left shoulder and decreased strength of the left shoulder and scapular muscles. It appeared that the claimant had completed at least 31 post-op therapy visits. Additional therapy was denied on peer review. Based on the records provided for review, additional therapy is not recommended. The ODG recommend 30 visits of therapy for an open surgical procedure involving repair of the rotator cuff. The claimant was nine months post - operative and appeared to have completed the recommended amount of therapy. While there was still some loss of motion and weakness, this can be addressed with a home exercise program. Additional formal therapy at nine months post surgery would not be of any significant benefit. The claimant should be actively participating in a home exercise program, which would allow for continued improvement without the need for additional formal therapy.

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.

- ODG – OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES.
Official Disability Guidelines (ODG), Treatment Index, 8th Edition (web), 2010, Shoulder: Physical therapy.

- 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).