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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT 3X4 shoulder left (A/PROM) (97010, 97014, 97035, 97110, 97124, 97140, 97530, 97116)

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

Denial letters, 2/15/10, 2/19/10

Official Disability Guidelines Treatment in Worker's Comp, 14th edition, 2010 updates;
Shoulder- Physical Therapy

Therapy notes: 10/28/09, 11/10/09, 11/12/09, 11/18/09, 11/20/09, 11/23/09, 11/25/09, 11/30/09, 12/02/09, 12/15/09, 12/18/09, 12/21/09, 12/23/09, 01/04/10, 01/06/10, 01/12/10, 01/14/10, 01/19/10, 01/21/10, 01/27/10, 01/29/10, 02/01/10 and 02/10/10.

Office Note, Dr.: 02/05/10

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who reported a left shoulder injury on xx/xx/xx. She was diagnosed with a superior labral anterior posterior (SLAP) tear, as well as rotator cuff syndrome. The claimant underwent left shoulder arthroscopic SLAP repair, decompression and distal clavicle excision on 10/01/09. She attended 28 sessions of postoperative physical therapy with noted improvement in motion and strength. Dr. saw the claimant on 02/05/10 and noted some persistent stiffness in the left shoulder. Radiographs showed the decompression and distal clavicle excision were in good position. Recommendation was made to continue physical therapy. A therapy note dated 02/10/10 indicated left shoulder flexion to 175 degrees, abduction to 170 degrees, internal rotation to 60 degrees, external rotation to 60 degrees and strength to 4+/5.

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

The evidence-based ODG guidelines recommend 24 sessions of physical therapy as a reasonable amount to complete rehabilitation following procedures such as a Bankart repair; i.e., repair for recurrent instability. This procedure would in many respects be similar to the

procedure performed on this claimant, i.e., SLAP repair. Records reflect that she has attended 28 sessions of therapy to date. She is reportedly seven months postop as of February 2010 and reportedly has a bit of stiffness. The most recent therapy note suggested essentially normal flexion with diminished strength. After 28 sessions of therapy, the ODG would recommend a home exercise program. The claimant has been through a reasonable course of physical therapy to date and it is unclear as to why, with excellent motion, that she would not be a candidate to transition to a home exercise program. As such, there is no clear indication for the requested additional sessions of therapy when considered in the context of the evidence-based literature. The reviewer finds that medical necessity does not exist for PT 3X4 shoulder left (A/PROM) (97010, 97014, 97035, 97110, 97124, 97140, 97530, 97116).

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Shoulder- Physical Therapy

When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT

Rotator cuff syndrome/Impingement syndrome: Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Complete rupture of rotator cuff: Post-surgical treatment: 40 visits over 16 weeks

Sprained shoulder; rotator cuff: Post-surgical treatment (RC repair/acromioplasty): 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)