



Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 5/5/10

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for:
Continued physical therapy (PT) to the right shoulder, 9 visits. (ICD-9: 97110).

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:

- 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:

Continued PT to the right shoulder, 9 visits. (ICD-9: 97110), cannot be considered medically necessary at this time. The previous denial is upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice to CompPartners, Inc. of Case Assignment dated 4/28/10.
- Company Request for IRO dated 4/27/10.
- Pre-Authorization Determination dated 4/26/10.
- Concurrent Review Determination dated 3/30/10.
- Request Form dated 4/26/10.
- History/Physical Examination dated 4/14/10.
- Referral Form dated 4/14/10.
- Physical/Occupational Therapy Rehab Assessment dated 4/8/10, 4/6/10, 3/30/10, 3/26/10, 3/25/10, 3/23/10, 3/18/10, 3/17/10, 3/16/10, 3/11/10, 3/9/10, 3/5/10, 3/4/10, 3/2/10, 2/26/10, 2/25/10, 2/23/10, 2/19/10, 2/18/10, 2/16/10, 2/12/10, 2/11/10, 2/9/10, 2/4/10, 2/2/10, 1/28/10, 1/26/10, 1/21/10, 1/19/10.
- History/Physical Exam dated 3/3/10, 2/8/10, 1/18/10, 12/4/09.
- Operative Report dated 1/6/10.
- Right Shoulder MRI dated 11/30/09.
- Follow-Up Visit dated 11/18/09, 10/21/09.
- Right Elbow X-Ray dated 4/22/09.

PATIENT CLINICAL HISTORY (SUMMARY):

Gender: Female

Mechanism of Injury: Described as secondary to a fall onto her outstretched right arm, resulting in sustaining an injury to her right shoulder.

Diagnosis: Right shoulder impingement, right shoulder acromioclavicular arthrosis.

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

The claimant is a female with a work-related injury date of xx/xx/xx. The request in review is for nine additional PT visits for the right shoulder. The claimant's mechanism of injury was described as when she fell at work onto an outstretched hand sustaining injury to her right

shoulder. The claimant underwent surgery on 01/07/10 for a preoperative diagnosis of impingement right shoulder and acromioclavicular arthrosis right shoulder. The operation performed was right shoulder arthroscopic subacromial decompression and distal clavicle excision. On review of the claimant's postoperative follow-up visits, there was no evidence of a surgical complication. On 02/08/10, approximately four weeks post-operation, the claimant had 90 degrees of active flexion and abduction. An aggressive PT program was instituted at that point. On 03/03/10, the claimant said she was getting a lot better, though slowly. Her examination revealed that the incision was good. She was feeling better, and there was no pain at the acromioclavicular joint area. The claimant's most recent evaluation dated 04/14/10, approximately three and one-half months post-operation, showed the claimant had 150 degrees of forward flexion and 120 degrees of abduction with very limited external rotation and internal rotation "to her belt loop." The claimant had good strength and no pain at the acromioclavicular (AC) joint. She had a positive Speed test and a positive O'Brien test. It was felt that the claimant had a "biceps tendinitis picture," and she underwent a cortisone injection to the anterior part of the shoulder. The claimant also had a request for a renewal of at least nine more PT visits.

Her medical record contained handwritten and illegible PT notes.

According to a 03/30/10 denial document, the claimant was reported to have already had 24 sessions of postoperative formal therapy and should have been transitioned to a home exercise program (HEP) already. A request for additional therapy at that time was modified for an approval for an additional three sessions to transition the claimant to a HEP. Considering the fact that the claimant has reached the maximum suggested PT visits (24 visits over 14 weeks), per ODG criteria for arthroscopic surgery for impingement syndrome, has had an allowed three additional visits for instruction for a HEP, and given claimant's progress with range of motion (ROM) as of 04/14/10, there has been no documentation of a reasoned medical explanation, as to why claimant at this point, will continue to require a supervised PT program over and above a HEP to continue with her postoperative rehabilitation and improvement of ROM.

Considering the factors in this claimant's case as mentioned above, the request for an additional nine sessions of PT for the right shoulder, cannot be considered medically necessary at this time. The previous denial is upheld.

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.

ODG Treatment in Worker's Compensation, 14th Edition, 2010 Updates,
Shoulder Chapter, PT; Rotator cuff syndrome/Impingement syndrome.

- 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).