

I-Decisions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Mar/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3xWk x 8Wks Left Shoulder

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

ER records: 10/13/XX

Dr. Clinic Notes: 10/19/XX, 10/27/XX, 11/10/XX, 12/10/XX, 01/12/XX, 02/10/XX

Initial Physical Therapy Evaluation: 10/25/XX

Daily Physical Therapy Treatment Notes: (x10) 10/27/XX, 11/01/XX, 11/05/XX, 11/08/XX, 11/10/XX, 11/13/XX, 11/17/XX, 11/19/XX, 11/22/XX, 11/30/XX

MRI Left Shoulder: 11/02/XX

Dr. Office Records: 01/10/XX, 02/23/XX

Left Shoulder X-Rays: 01/10/XX

Physical Therapy Re-Evaluation/Progress Note: 01/13/XX, 03/08/XX

Peer Reviews: 01/24/XX, 02/03/XX

Dr.- DDE: 03/04/XX

Official Disability Guidelines, Chapter: Shoulder, Physical Therapy

PATIENT CLINICAL HISTORY SUMMARY

This XX-year-old right hand dominant male claimant sustained a left shoulder injury while at work on XX/XX/XX when he was kicked in the left shoulder by a large animal while loading a truck. His diagnosis is left shoulder rotator cuff sprain/contusion, left shoulder pain, impingement syndrome, acromioclavicular joint (AC joint) sprain, partial rotator cuff tear and mild adhesive capsulitis. X-rays obtain in the emergency room following his injury were negative. Dr. treated the claimant starting on 10/19/XX with medications, activity modifications, physical therapy and an MRI. Physical therapy initiated on 10/25/XX and revealed decreased range of motion, endurance and strength with pain and muscle tightness. He completed 10 physical therapy sessions from 10/27/XX through 11/30/XX. A left shoulder MRI completed on 11/02/XX revealed an intra-substance tear at musculotendinous junction of left supraspinatus. An orthopedic evaluation completed on 01/10/XX indicated some improvement with physical therapy with continued difficulties with overhead or away from body movements of the left shoulder. Left shoulder x-rays revealed in-congruency of the AC joint. Continued physical therapy was prescribed. The 01/13/XX physical therapy re-evaluation indicated he was last seen in 11/XX, had not returned to work and reported continued left shoulder pain with any attempted movement. He had continued decreased range of motion, strength and endurance along with pain and muscle tightness. Additional physical therapy had been denied on two prior peer reviews. The 02/23/XX orthopedic follow

up exam demonstrated "ATE" of 150 degrees, external rotation to the top of his head and internal rotation to his gluteal region all with pain. He had a positive O'Brien test, pain and mild weakness with drop-arm test, tenderness over the AC joint and a positive cross-body adduction test. Surgery was discussed and continued physical therapy prescribed.

A designated doctor exam completed by Dr. on 03/04/XX determined the claimant was at maximum medical improvement with 2 percent whole person impairment. A physical therapy re-evaluation completed on 03/08/XX revealed active range of motion, all with pain, that measured 90 degrees flexion, 35 degrees extension, 85 degrees abduction, 30 degrees adduction, 30 degrees external rotation, normal internal rotation, 90 degrees scaption and 65 degrees supraspinatus. Active assisted range of motion with pain measured 145 degrees flexion, 40 degrees extension, 120 degrees abduction, 30 degrees adduction, 65 degrees external rotation, normal internal rotation, 120 degrees scaption and 75 degrees supraspinatus. He was moderately tender at the supraspinatus insertion and lateral deltoid and slightly less at the anterior/posterior left shoulder. His strength was fair in flexion, abduction, external rotation, scaption and supraspinatus with good strength in extension, adduction and internal rotation. He had catching pain in abduction and flexion and moderate muscle tightness of the left shoulder girdle that was worse in the upper traps and rhomboids.

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

This claimant was injured approximately XX months ago and was treated with 10 physical therapy visits from October 20XX to November 20XX after which time there was a gap in documentation of physical therapy until a therapy evaluation on 01/13/XX. With this gap in treatment, it is not clear that this claimant received any significant benefit from the treatment. At a Designated Doctor Examination it was determined that the claimant had reached maximum medical improvement, and the February 20XX provider note indicated that surgical intervention had been discussed. At this juncture post injury, it is not clear that additional therapy would provide benefit over and above that which could be achieved with a home exercise program and the request therefore, cannot be recommended as medically necessary. The reviewer finds no medical necessity at this time for Physical Therapy 3xWk x 8Wks Left Shoulder.

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 KNOWLEDGBASE
- 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)