

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jan/31/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Six sessions of physical therapy for the right 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**

04/24/09 Records of Dr.

05/21/09 Dr. record

02/17/10, 06/03/10 Office notes of Dr.

02/19/10, 12/02/10 physical therapy notes

Records of Dr. 04/05/10

Records of Dr. 12/01/10

Peer reviews 12/08/10, 12/13/10

Official Disability Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

This is a female who was status post right shoulder rotator cuff repair in xx/xx. Reportedly, the claimant has undergone 28 sessions of postoperative therapy. Dr. evaluated the claimant on 06/03/10. Abduction was to 150 degrees. Forward flexion was to 150 degrees. External rotation was to 30 degrees. Dr. felt that the claimant had adhesions and recommended physical therapy. Dr. saw the claimant for a 2nd opinion. Dr. noted that the claimant performed a home exercise program only occasionally. External rotation was to 60 degrees and internal rotation was to 45 degrees. Abduction was to 125 degrees. Forward flexion was to 135 degrees. The 12/02/10 physical therapy note documented flexion to 168 degrees, extension to 30 degrees, and external rotation to 40 degrees. Strength of the external rotators was 3+/5. Six Additional therapy visits were recommended and denied by the insurance company.

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

Six sessions of physical therapy for the right shoulder are not medically necessary based on the records provided in this case. For the diagnosis of adhesive capsulitis, 16 visits over 18

weeks is recommended by ODG for medical treatment of this problem. This claimant is status post a right shoulder rotator cuff repair performed in xxxx and did therapy for that, then continued to have problems and was evaluated in 06/10 for her right shoulder. There was concern at that time for adhesive capsulitis. However, in an exam note dated 12/1/2010, Dr. states that "therapy at this point would probably not be beneficial unless she absolutely does her motion several times a day as instructed for a prolonged period of time." The reviewer finds no medical necessity for 6 additional sessions for physical therapy right shoulder at this time.

**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)