

US Resolutions Inc.

An Independent Review Organization
1115 Weeping Willow
Rockport, TX 78382
Phone: (512) 782-4560
Fax: (207) 470-1035
Email: manager@us-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Feb/17/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Occupational Therapy 3xwk x 4wks 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

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a xx year-old female who sustained a work related injury to her right shoulder. As the claimant was lifting, she felt pain and popping in her shoulder. When she saw Dr. on 10/15/10, the claimant had right shoulder pain and popping with range of motion. She had pain with active and passive forward elevation and weakness of her rotator cuff as well as pain with resistance to her rotator cuff. She had no instability. X-rays of her right shoulder in Dr. office showed no acute bone abnormality. Dr. recommended and MRI of the claimant's right shoulder. There was no radiology report of an MRI provided. Dr. noted on 11/05/10 that an MRI (no date provided) showed tendonitis and rotator cuff tendonitis but no signs of rotator cuff tear. Dr. gave the claimant a cortisone injection in her right shoulder on 11/05/10. The claimant had an initial evaluation for occupational therapy on 11/10/10. It was noted that an MRI on 10/29/10 revealed a subacromial spur, subacromial subdeltoid bursitis and supraspinatus tendinosis. Again there was no radiology report provided. On examination the claimant had a flexion of 122 degrees, extension of 35 degrees, abduction of 80 degrees, internal rotation of 60 degrees and external rotation of 70 degrees. The claimant had positive Hawkin's O'Brien's and Neer tests. On 12/17/10 Dr. noted that the claimant was not getting much improvement with occupational therapy. She still had pain with active and passive forward elevation and weakness of the rotator cuff and tenderness over the parascapular muscle. Dr. recommended continuing conservative treatment.

On 01/14/11 an occupational therapy note indicated that the claimant's symptoms were

unchanged. The claimant's range of motion had actually diminished with flexion that was 118 degrees, but initially was 120 degrees and abduction that was 75 degrees, but initially was 80 degrees. External rotation was 52 degrees and initially had been 60 degrees. Recommendation was to continue therapy. This was denied in a peer review dated 01/21/11 as the additional visits exceeded the guidelines and there were no exceptional factors mentioned to consider extra sessions. The second peer review dated 01/28/11 also noncertified the additional sessions because there was lack of documented functional improvement.

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

The claimant was injured while lifting. She had a previous left shoulder surgery in 05/09. This request is for additional right shoulder occupational therapy. The right shoulder MRI on 11/05/10 did not demonstrate any evidence of rotator cuff tearing or labral disc continuity. The radiographs previously demonstrated no acute burning abnormality. Typical guidelines recommend 10 visits over 8 weeks. The claimant has had at least 9 sessions of occupational therapy and it is unclear what benefit further treatment may provide. Based on review of the medical records, the reviewer finds that medical necessity does not exist for Occupational Therapy 3xwk x 4wks right shoulder.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates.
Shoulder:

ODG Physical Therapy Guidelines

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

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)