



7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/20/10

**IRO CASE #:**

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

Continued Post-operative physical therapy 3 times per week x 4weeks

### **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.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Office visit, notes, physical therapy assessments, MRI reports, surgical reports, previous denials.

### **PATIENT CLINICAL HISTORY:**

Patient Name:

Patient DOB: xx/xx/xx

Patient DOI: xx/xx/xx

MRI Left shoulder: 6-8-2010: supraspinatus incomplete tear left shoulder

Patient DOS: 7-29-2010 ( SAD, DCR, RCR, biceps tenotomy, labral debridement)

Patient Diagnosis: s/p Left Shoulder Arthroscopy, Rotator Cuff Repair, Left Shoulder Brachial Plexopathy

Treatment Requested: Outpatient Physical Therapy 3 times a week for 3 weeks, 9 sessions total (requested 11-24-2010)

Treatment Goals: based on therapy notes of 10-29-2010 and 11-10-10 clinical notes: increase flexion actively to 165 degrees (from 155 currently), increase external rotation to 90 degrees (from 85 currently), increase global shoulder strength to 5/5 (from 4+/5 to 5/5 currently), and decrease pain to 0-2/10 (from 2-4/10 currently).

IW is a male who sustained an acute rotator cuff tear on xx/xx/xx after a box fell onto his left shoulder. He was diagnosed to have a rotator cuff tear and a type III acromion by 6-8-2010. Due to pain and decreased function, he underwent shoulder arthroscopy on 7-29-2010 with rotator cuff repair, distal clavicle resection, and debridement of a slap lesion. He underwent postoperative rehab from 7-29-2010 to 11-24-2010 with improvement in function and pain scores. He appears to have sensory disturbances of numbness and tingling postoperatively and underwent diagnostic EMG /NCS showing a mild brachial plexopathy manifested by numbness in his small finger. On 10-29-2010, additional therapy is requested it appears to address the plexopathy based on the clinical notes of the treating surgeon on 11-10-2010, but also to address the postoperative shoulder arthroscopy based on the 10-29-10 clinical notes.

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

Using the ODG treatment guidelines in the Shoulder chapter, 24 sessions are the maximum number of recommended sessions of physical therapy in the absence of a complete tear of the rotator cuff. If the goals are to improve the range of motion and function of his shoulder, based on the IW current functional range of motion and pain scores achieved after 24 sessions of therapy and based on the 10-29-2010 therapy assessment note, this can be achieved by transitioning the IW to a home exercise program, in my opinion. The IW has already had 24 sessions of therapy and objectively is within minimal functional requirements for

shoulder function with respect to range of motion and pain reduction. The additional range of motion gains may be reasonably achieved by transitioning the IW to a home exercise program in my opinion. If however the goals of additional therapy are to address his postoperative brachial plexopathy, further substantiating patient complaints and examination findings should be submitted in order to clearly delineate current deficits due to the plexopathy, and the therapeutic goals to address it.

### **REFERENCES**

ODG treatment guidelines, Work Loss Data Institute. Shoulder (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 191 p.

### **A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN 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**



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- 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)**