

**SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.**  
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Notice of Independent Review Decision

**DATE OF REVIEW:** April 25, 2011

**IRO CASE #:**

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

Occupation Therapy for the Left Shoulder three times a week for four weeks. CPT Codes 97530, 97110, 97035, 97014 and G0283.

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

AMERICAN BOARD OF ORTHOPAEDIC SURGEONS

**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:**

The patient is a male who is an employee of xxx On his date of injury, the patient picked up a box to move it and he felt pain in his left shoulder.

Subsequent to this, the patient was seen at Medical Centers where he was diagnosed with a shoulder sprain and shoulder pain.

Subsequently on short order, Medical Centers referred the patient to M.D.,. The patient was seen for the first time by Dr. on xx/xx/xx . He gave a diagnosis of sprain and cuff injury.

Subsequently, Dr. ordered an MRI. The MRI revealed advanced osteoarthritic changes in the glenohumeral joint, subluxation of the humeral head, subscapular recess of loose bodies (which were probably felt to be intra-articular), bicipital tendonitis, and an incomplete tear of his rotator cuff.

Of significance, the patient had a history of collagen vascular disease, Lupus, and also vascular and circulatory problems secondary to that. He also had a history of avascular necrosis of the hips, probably as a result of the treatment of his Lupus.

The patient subsequently was ordered to have a course of physical therapy, which was instituted under Dr. request.

Since that time, the patient has undergone a prolonged course of physical therapy without significant relief. The patient continues to have limited motion, although he has had intermittent improvement with his symptoms.

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

There is a request for further physical therapy, i.e. occupational therapy. The patient recently had an exacerbation of his symptoms and was seen by O.T.R. Ms. examined the patient and felt he had significant rehabilitative potentials. She recommended a course of occupational therapy of three to six visits over three weeks and followed by four to eight visits over four weeks. She also suggested different modalities of treatment. At this point the patient has undergone significant physical therapy treatments immediately following his injury and that he has exceeded the recommendations of the ODG Guidelines. The patient does have osteoarthrosis of the shoulder which entitles him to nine visits over eight weeks. The patient has far exceeded this, and I do not see the purpose for reinstating an organized plan of physical therapy. The fact that the patient has performed an extensive course of therapy, he has been educated to the point where he can continue doing this at home, possibly with a pulley and exercise bands. However, this patient has, as previously stated, comorbidities, i.e. Lupus, arthritis and significant degenerative changes within the shoulder joint. At this point in time, it would be fruitless to continue with conservative treatment. The patient most probably will require an arthroplasty of some type in his shoulder, depending upon the condition of his rotator cuff. Perhaps, there is enough cuff there to do a standard total joint arthroplasty versus a reverse shoulder which has been fraught with problems, especially in a male of this age who does significant heavy physical work. For this reason, the appeal for the request of occupational therapy should not be granted. The patient should be directed to receive more definitive care.

If I can be of further assistance, please let me know.

**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
- 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)