

SENT VIA EMAIL OR FAX ON
Apr/02/2012

True Resolutions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Apr/02/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 2 x a week for 6 weeks

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Orthopedic Surgery

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

OD Guidelines
Utilization review worksheet and utilization review determination 01/30/12
Utilization review work sheet 02/10/12
Utilization review determination 02/13/12
Pre-authorization request form 01/26/12
Physical therapy prescription form 01/26/12
Daily notes 12/13/11
Shoulder evaluation 12/07/11
Appeal request additional physical therapy 02/06/12
Office notes MD 11/01/11-02/29/12
Operative report left shoulder diagnostic arthroscopy, subacromial decompression and distal clavicle resection 08/25/06
MRI arthrogram right shoulder 01/23/12
MRI arthrogram left shoulder 05/08/06

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a female who sustained an injury on xx/xx/xx when she was lifting a trash bag and experienced a significant amount of right shoulder pain. The claimant has a remote history of left shoulder arthroscopic surgery performed 08/25/06. MRI arthrogram of the right shoulder performed 01/23/12 revealed findings suspicious for SLAP type tear of the labrum; mild tendinosis of supraspinatus and infraspinatus with mild partial thickness articular surface tearing of the anterior supraspinatus and junction of supraspinatus and infraspinatus tendons at their insertions. There also is mild acromioclavicular osteoarthritis noted. The claimant was seen in follow-up on 01/26/12 and reports she is still having some discomfort. She rates her pain 5-6/10 at its worst. Her pain is usually aggravated with prolonged lifting and with overhead activities. She has tried Advil which helps slightly with her pain. Right shoulder examination reported full range of motion, with no tenderness. Neer's impingement test was moderately painful, and Hawkin's was mildly painful. There was trace to 1+ posterior manual translation. Shoulder abduction strength was 4+/5 with pain. External rotation strength was 5/5. Sensation was normal. Treatment options were discussed and it was noted that there was no reason seen for her to proceed with surgery at this time. She was given the subacromial corticosteroid injection on this date and she was referred back to physical therapy.

A request for continued physical therapy two times a week for six weeks was reviewed on 01/30/12. The case was discussed with Dr. noted that Dr. is concerned regarding the claimant's increased pain and limitations in range of motion. MR arthrogram was pending and his plan includes no further work or therapy until MR result is known. Tedda stated that current request should be considered withdrawn.

A reconsideration for continued physical therapy two times a week for six weeks was determined as not medically necessary. The reviewer noted that it appears the claimant had already completed 12 physical therapy sessions with a current request for additional 12 therapy sessions. The record contains a 01/26/12 orthopedic evaluation for follow-up of right shoulder pain suspicious for possible labral injury. Physical examination showed full range of motion. There was moderately painful Neer test and mildly painful Hawkin's test. Shoulder abduction strength was 4+/5 with pain. External rotation strength was 5/5. MRI was reviewed and claimant's assessment is right shoulder internal derangement, possible small SLAP tear, mild acromioclavicular joint arthrosis, and posterior laxity instability. Subacromial corticosteroid injection was performed and physical therapy was ordered. The reviewer noted that per Official Disability Guidelines, up to 10 visits of therapy are indicated for rotator cuff syndrome, impingement syndrome. It appears the claimant has already attended a number of therapy sessions exceeding guidelines, and the additional sessions would then add additional excess of physical therapy treatments. It was noted physical examination revealed no objective evidence of significant impairment which would necessitate further supervised physical therapy over and above home exercise program, therefore reconsideration request for continued physical therapy 2 times a week for 6 weeks cannot be considered medically necessary.

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

Based on the clinical information provided, the proposed physical therapy 2x6 is not supported as medically necessary. The claimant is noted to have sustained an injury to right shoulder on xx/xx/xx. MRI arthrogram of the right shoulder on 01/23/12 reported findings suspicious for SLAP type tear of labrum with no other evidence of labral tear seen. There was mild tendinosis of supraspinatus and infraspinatus with mild partial thickness articular surface tearing, and mild acromioclavicular osteoarthritis. Records indicate the claimant was treated conservatively with physical therapy and subacromial corticosteroid injection of right shoulder. Per office note dated 02/29/12, the claimant reported good response from subacromial injection. Previous review indicated that the claimant had completed 12 physical therapy visits. Per Official Disability Guidelines, up to 10 visits over eight weeks may be indicated for rotator cuff syndrome and/or impingement syndrome. Noting that the claimant already has completed physical therapy in excess of guidelines, additional therapy is not warranted. There is no evidence of exceptional factors that would support the need for

additional therapy that exceeds guidelines either in duration or number of visits. At this time it appears that nothing more than an independent home exercise program would be appropriate.

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)