

SENT VIA EMAIL OR FAX ON  
Mar/21/2012

# Independent Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/21/2012

**IRO CASE #:**

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

Additional Post-Op Physical Therapy Left Shoulder X 2 sessions; Therapeutic Activities Left Shoulder X 2 sessions

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

Board Certified Orthopedic Surgeon (Joint)

**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 adverse determination 01/09/12

Utilization review reconsideration adverse determination 01/27/12

Employer's first report of injury or illness 03/21/11

clinic notes 03/21/11-04/19/11

MRI left shoulder 03/30/11

Office notes 04/18/11-07/21/11

Follow-up notes 06/08/11-02/02/12

Weekly therapy progress note 06/16/11-06/30/11

Physical performance evaluation 07/07/11, 11/17/11, and 01/13/12

Operative note left shoulder arthroscopy with subacromial decompression, bursectomy, SLAP repair, mini open rotator cuff repair and synovectomy 10/12/11

Preauthorization request form 01/03/12

**PATIENT CLINICAL HISTORY SUMMARY**

The injured worker tripped and fell on xx/xx/xx when he fell landing on outstretched left arm and injuring his shoulder. The injured worker was initially treated conservatively with physical therapy and cortisone injection with some temporary relief. The claimant also had anti-inflammatory medications, analgesics, and activity modification without significant improvement. MRI left shoulder performed 03/30/11 revealed small shoulder joint effusion and larger anterior subdeltoid bursal fluid collection, with findings indicative of full thickness

tear, although severe tendinopathy was also possible. Acromioclavicular joint arthropathy and hypertrophy impinging on rotator cuff outlet for supraspinatus tendon also was noted. After failing a course of conservative treatment, the injured worker underwent surgical intervention to left shoulder on 10/12/11 including left shoulder arthroscopy with subacromial decompression, bursectomy, SLAP repair, mini open rotator cuff repair and synovectomy. Following surgery the injured worker participated in a course of physical therapy. Follow-up on 11/14/11 reported left shoulder range of motion abduction 60 degrees, flexion 60 degrees. There was diffuse pain on palpation of the left shoulder. There was decreased strength 3/5 in the left shoulder. Sensation was within normal limits. There was positive apprehension sign. A request for additional post-op physical therapy left shoulder times two sessions, therapeutic activities left shoulder times two sessions was reviewed on 01/09/12 and determined as not medically necessary. It was noted that the claimant is status post left shoulder surgery on 10/12/11. He has complaints of left shoulder pain. The operative report documents a mini open rotator cuff repair. Examination on 11/14/11 the injured employee reported pain level 7/10. Exam showed abduction 60, flex 60, and 3/5 strength. 12 sessions of therapy were authorized. There are no current clinical notes that document a specific subjective complaint on physical examination findings. The claimant has reportedly attended 13 sessions of therapy the request is now for two more therapy sessions. There were no current clinical notes that document specific subjective complaints or physical examination findings, and there is no way to determine if there has been progress with the prior treatment. Adverse determination was recommended.

A reconsideration request for additional post-op physical therapy to the left shoulder was reviewed on 01/27/12 and request was determined as not medically necessary. It was noted the injured employee is status post left shoulder arthroscopy, SAD, bursectomy, labral repair, mini open rotator cuff repair 10/12/11. On 11/14/11 pain level was 7/10. Exam showed abduction 60, flexion 60 and 3/5 strength. 12 sessions of therapy were authorized on 11/18/11. Only the original 11/14/11 clinical note previously reviewed and a 01/13/12 functional capacity evaluation were submitted for review. It was recommended upholding initial adverse determination. It was noted that the 11/14/11 note is prior to the 11 supervised rehab sessions performed and the 01/13/12 functional capacity evaluation does not include a shoulder examination. Additional supervised rehab is thus not supported since there is no documentation of current subjective complaints, current clinical findings and progress made in supervised rehab.

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

The request for additional post-op physical therapy to the left shoulder times two sessions; therapeutic activity left shoulder times two sessions is indicated as medically necessary. The injured employee tripped and fell injuring his left shoulder. He underwent mini open rotator cuff repair, subacromial decompression, SLAP repair on 10/12/11. Records indicate he completed 13 visits of post-op physical therapy. Most recent progress note dated 02/02/12 noted range of motion of the left shoulder with abduction of 75 degrees and flexion 90 degrees. Strength was decreased 4/5 in the left shoulder. Apprehension sign was positive on the left. Functional capacity evaluation on 01/13/12 noted shoulder range of motion flexion 81, extension 21, horizontal adduction 0, abduction 76, internal rotation 46 and external rotation 45. Noting that the claimant still has significant deficit in range of motion as well as weakness, additional post-op therapy is supported as medically necessary. The injured employee has had only 13 sessions of therapy to date. Per Official Disability Guidelines up to 30 visits of post-op therapy is supported following open rotator cuff repair. As such previous denials are recommended as overturned on IRO.

**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)