

# US Decisions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Oct/14/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** physical therapy for the right shoulder - 6 visits

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

**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 medical necessity exists for each health care service in dispute.** It is the opinion of the reviewer that the request for physical therapy for the right shoulder - 6 visits is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Utilization review determination dated 09/06/13, 09/16/13  
Office note dated 08/14/13, 07/31/13, 07/17/13, 07/03/13, 06/19/13, 06/05/13, 05/24/13, 05/20/13, 06/01/12, 05/29/12, 05/07/12, 05/02/12, 04/23/12, 04/09/12, 03/26/12, 03/05/12, 02/20/12, 02/08/12, 01/30/12, 01/24/12, 01/16/12, 11/23/11, 12/05/11, 11/09/11, 09/07/11, 10/03/11, 10/28/11, 08/24/11, 09/06/11, 08/12/11  
Soap notes dated 07/18/13, 07/16/13, 07/05/13, 08/21/13, 08/30/13, 08/28/13, 09/06/13, 09/05/13, 09/04/13, 08/16/13, 07/31/13  
Operative report dated 02/07/12, 05/23/13, 08/23/11  
MRI right shoulder dated 08/05/13, 05/25/12  
Right shoulder arthrogram dated 08/05/13, 10/26/11, 07/26/11  
Letter dated 09/19/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female whose date of injury is xx/xx/xx. On this date the patient was shoved into a wall. The patient underwent right shoulder arthroscopy with repair of glenoid labrum SLAP lesion on 08/23/11. The patient subsequently underwent right shoulder arthroscopy with repair of glenoid labrum tear on 02/07/12 followed by a course of postoperative physical therapy. The patient underwent right shoulder excision of distal clavicle, acromioplasty and rotator cuff repair on 05/23/13. MRI right shoulder dated 08/05/13 revealed prior labral tear repairs, prior rotator cuff repairs, no recurrent rotator cuff tear, muscle bulk of the rotator cuff musculature appears intact, deltoid muscle bulk appears normal. Note dated 08/14/13 indicates that there is no indication for further surgery. On physical examination flexion is 95 and abduction is 90 degrees. Soap note dated 09/06/13 indicates that the patient has completed 42 physical therapy visits since

05/24/13. Completion of home exercise program is noted to be questionable.

Initial request for 6 physical therapy visits was non-certified on 09/06/13 noting that given the 40 sessions of physical therapy without relief of symptomatology and reported persistent symptoms, the patient would best be advanced to a home exercise program. This is consistent with evidence based medicine, Official Disability Guidelines and the reviewer's training and experience as an orthopedic surgery. The Official Disability Guidelines typically recommend 30 visits over 18 weeks. The patient has already had 40 sessions. The denial was upheld on appeal dated 09/16/13 noting that the patient has far exceeded the recommended number of postoperative physical therapy sessions for her condition. However, it appears that the patient has developed adhesive capsulitis post shoulder surgery as her range of motion remains at 90-95 degrees in flexion and abduction. While additional physical therapy may well be indicated, the medical records do not establish that the patient has undergone an injection in the treatment of this condition to indicate the need for additional physical therapy.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient underwent right shoulder excision of distal clavicle, acromioplasty and rotator cuff repair on 05/23/13 and has completed 42 postoperative physical therapy visits to date. The Official Disability Guidelines would support up to 30 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. It is noted on the note dated 08/14/13 that the patient's compliance with a home exercise program is questionable. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for physical therapy for the right shoulder - 6 visits is not recommended as medically necessary.

**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)