

# US Resolutions Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Jan/30/2014

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** PT/OT x 12 for right shoulder

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** M.D., Board Certified Orthopedic Surgeon

**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 PT/OT x 12 for right shoulder is not recommended as medically necessary.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. The patient was throwing trash into a dumpster and noted the onset of pain in the right shoulder. The patient sustained a right shoulder full thickness rotator cuff tear and underwent right shoulder arthroscopic rotator cuff repair with debridement, subacromial decompression and distal clavicle excision on xxxxx. The patient has completed approximately xxxx postoperative therapy visits to date. Occupational therapy re-evaluation dated 12/09/13 indicates that the patient's pain radiates into the right side of the neck, the right shoulder and the right arm. On physical examination right shoulder range of motion is flexion 120, extension 20, abduction 90, adduction 5, external rotation 50 and internal rotation 35 degrees. Grip strength is 94 pounds on the left and 36 pounds on the right. Note dated 12/10/13 indicates that the rotator cuff is functional. He elevated to 160 degrees, external rotation to 55 degrees. Abduction strength testing revealed minimal weakness.

Initial request for PT OT x 12 for right shoulder was non-certified on 12/13/13 noting that there are no medical records from the treating AP. There is no operative note or clinical rationale for additional supervised PT. There is no objective assessment of response to PT. The claimant should be able to transition to a home exercise program. The request exceeds evidence based guidelines. The denial was upheld on appeal dated 01/02/14 noting that there are no reasons stated as to why the claimant cannot continue with a self-guided program to improve range of motion more. The claimant has received 24 postoperative PT sessions to date.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient sustained a right shoulder full thickness rotator cuff tear and underwent right shoulder arthroscopic rotator cuff repair with

debridement, subacromial decompression and distal clavicle excision on 08/23/13. The patient has completed approximately 24 postoperative therapy visits to date. The Official Disability Guidelines support up to 24 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. 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 PT/OT x 12 for right shoulder 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)