



## CompPartners Final Report



CompPartners Peer Review Network  
Physician Review Recommendation  
Prepared for TDI/DWC

**Claimant Name:** \_\_\_\_\_  
**Texas IRO #:** \_\_\_\_\_  
**MDR #:** M2-06-1600-01  
**Social Security #:** XXX-XX-\_\_\_\_\_  
**Treating Provider:** Gwendolyn Whigham, D.C.  
**Review:** Chart  
**State:** TX  
**Date Completed:** 8/1/06

### **Review Data:**

- **Notification of IRO Assignment dated 6/23/06, 1 page.**
- **Receipt of Request dated 6/26/06, 1 page.**
- **Medical Dispute Resolution Request/Response dated 6/9/06, 2 pages.**
- **Table of Disputed Services (date unspecified), 1 page.**
- **List of Treating Providers (date unspecified), 1 page.**
- **Prescription dated 4/27/06, 1 page.**
- **Letter to Claimant dated 5/23/06, 5/22/06, 3 pages.**
- **Fax Cover Sheet dated 5/16/06, 1 page.**
- **Letter to Medical Review Division dated 6/15/06, 1 page.**
- **Case Review dated 5/23/06, 5/19/06, 6 pages.**
- **Patient Information (date unspecified), 1 page.**
- **Follow-up dated 4/24/06, 1 page.**
- **Preauthorization dated 5/22/06, 5/16/06, 2 pages.**
- **Examination dated 10/8/04, 1 page.**

**Reason for Assignment by TDI/DWC:** Determine the appropriateness of the previously denied request for physical therapy, three times a week for four weeks.

**Determination: UPHELD** - previously denied request for physical therapy, three times a week for four weeks.

### **Rationale:**

**Patient's age:** 47 years

**Gender:** Male

**Date of Injury:** \_\_\_\_\_

**Mechanism of Injury:** Not provided for review.

**Diagnoses:** Post surgical repair of superior labral anterior-posterior (SLAP) lesion, right shoulder, on 10/8/04.

A prescription from Dr. Jarolimek, dated 4/27/06, requested rehabilitative physical therapy at three times a week for four weeks for a post surgical right shoulder superior labral anterior-posterior repair, which was performed on 10/8/04. The notes on this case indicated that he had undergone ongoing physical therapy through at least October of 2005 and completed 4 weeks of a work hardening program. Previous peer review found this request non-certified due to lack of clinical information to support this request at 20 months post surgery. The actual 4/27/06 office note from Dr. Jarolimek, MD indicated that he continued to complain of discomfort in the right shoulder. He was, at that time, in physical therapy. He stated that his range of motion was improving. A physical examination revealed range of motion of the right shoulder with 120 degrees in abduction, 160 degrees in forward flexion and 60 degrees in external rotation. Cross body adduction was elbow to contralateral mid clavicle and internal rotation right thumb to L1, as compared to left thumb to T5. Muscle spasms were present along the medial border of the right scapula. He was declared temporarily completely disabled. Continued supervised active rehabilitation and passive stretching was advised. The patient notes dated 5/22/06 from his chiropractor performing the rehabilitation indicated that he was getting physical therapy 3 times a week for 4 weeks, for low back pain that radiated to the lower extremities to the foot. There was also a notation of sexual dysfunction interfering with his daily activities. He continued to complain of discomfort in the right shoulder also. The current request is to determine the medical necessity for previously denied physical therapy at three times a week for four weeks as prescribed by Dr. Jarolimek. The medical necessity could not be established with the available information. There was no clinical information with regard to pain scale ratings. No deficits with muscle strength losses or in reflexes were noted, and no positive orthopedic test findings were indicated except for mild restriction of range of motion in internal rotation. There was no reported re-injury noted. There was no new diagnostic testing submitted or offered for review that would change his post-surgical condition. There was no description of reasons for flare up occurrence or if it was just ongoing since the injury. This claimant had already received an excessive time period of ongoing physical therapy visits for his post surgical shoulder, which was now approximately 21 months post surgery. He had also received an undetermined amount of ongoing physical therapy for his low back complaints, which is another issue unrelated to this review. The Official Disability Guidelines indicates that rehabilitation visits recommended would be twenty-four visits over fourteen weeks for rotator cuff repair and that a complete rupture repair would allow for up to forty visits over sixteen weeks. Therefore, this claimant's ongoing treatments had far exceeded any recommended allowances per these guidelines, and he should be capable of home exercises by now. Additionally, the ACOEM Guidelines, Chapter 6 indicates that, if a patient fails to functionally improve as expected with treatment, the patient's condition should be reassessed in order to identify incorrect or misdiagnoses. Further treatment should be appropriate for the diagnosed condition and should not be performed simply because of continued reports of pain. The ACOEM Guidelines, Chapter 9 for shoulder also does not support the efficacy of manipulation, manual therapy or passive modalities, such as massage therapy/myofascial release. Given these facts and the appreciation that this injured worker has already completed a work hardening program, this reviewer feels that additional physical therapy would not offer any further curative benefits.

**Criteria/Guidelines utilized:** ACOEM Guidelines, 2<sup>nd</sup> Edition, Chapters 6 and 9.  
Official Disability Guidelines, 9<sup>th</sup> Edition, Work Loss Data Institute Special Edition, Top 200 Conditions, 2004, page 154.

**Physician Reviewers Specialty:** Chiropractor

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**Physician Reviewers Qualifications:** Texas Licensed D.C, and is also currently listed on the TDI/DWC ADL list.

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.**

#### Your Right to Appeal

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code § 413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

In accordance with Division Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, requestor, claimant and the Division via facsimile or U.S.

Postal Service from the office of the IRO on this day of August 1, 2006.

Signature of IRO Employee:

Printed Name of IRO Employee **Lee-Anne Strang**

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