
Notice of Independent Review Decision

DATE OF REVIEW: 10/18/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical therapy (10-12 visits)

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

This case was reviewed by a board certified physical medicine and rehabilitation specialist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

<i>Primary Dx Code</i>	<i>HCPCS/ NDC</i>	<i>Units</i>	<i>Begin/End Date</i>	<i>Type Review</i>	<i>Amt Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Uphold / Overturned</i>
840.7	97110	10	9/22/07-10/22/07	Prospective				Uphold

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 10/1/07.
2. Determination Notices – 8/27/07 and 9/14/07.
3. Records and Correspondence from Therapy – 6/8/07-9/10/07.
4. Records and Correspondence– 6/11/07-9/17/07.

PATIENT CLINICAL HISTORY:

This case concerns an adult female who sustained a work related injury. Records she injured her left shoulder while carrying a heavy coffee urn. Diagnoses have included left shoulder pain. Evaluation and treatment for this injury has included surgery (arthroscopic subacromial, arthroscopic distal clavical resection and superior labral anterior posterior repair) and physical therapy.

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

The case concerns a female who sustained a work related injury of her left shoulder while carrying a coffee urn weighing approximately 25 pounds. She underwent left shoulder arthroscopic surgery, arthroscopic distal clavicle resection and superior labrum anterior posterior repair on May 23, 2007. At issue is the request for an additional 10 sessions of outpatient physical therapy. This request was denied by a medical reviewer on August 27, 2007 and again on September 14, 2007.

I recommend the denial be upheld. The review of the available medical documentation indicates that the enrollee has received 26 post-operative physical therapy treatments. She was examined by her orthopedic surgeon on September 10, 2007. On that date, the enrollee had already been out of physical therapy for 3 weeks. Office visit notes indicate that the enrollee had full shoulder range of motion with the exception of internal rotation. Her strength was 4/5 (defined as movement possible against some resistance by the examiner). She was to follow up with her surgeon in 4 weeks with anticipation of referral for a final impairment rating. No physician recommendations for additional physical therapy are recorded.

Official Disability Guidelines (ODG) for physical therapy for post surgical arthroscopic shoulder treatment includes 24 visits over 14 weeks. ODG physical therapy guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active-self-directed home physical therapy.

The review has determined that adequate supporting documentation showing medical necessity for an additional 10-12 sessions of physical therapy beyond the 26 already provided was not submitted with the request for reconsideration. The requested services cannot be recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN 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 TCADA 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)