

## **I-Decisions Inc.**

*An Independent Review Organization*

71 Court Street

Belfast, Maine 04915

(207) 338-1141 (phone)

(866) 676-7547 (fax)

### **Notice of Independent Review Decision**

**DATE OF REVIEW:** 05/04/08

**IRO CASE #:**

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

Physical therapy three times a week for three weeks to the left shoulder, 97110, 97140, and 97530.

### **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)

Upon independent review the reviewer finds that the requested physical therapy three times a week for three weeks to the left shoulder, 97110, 97140, and 97530 is not medically necessary.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse determination letters, 03/24/08 and 04/15/08

ODG Guidelines and Treatment Guidelines

Evaluations, 04/28/08, 04/07/08, 03/17/08, 02/18/08, 01/28/08, 01/10/08, 12/13/07, 11/16/07, 11/08/07, 09/13/07, 08/23/07

Chart Note, 04/14/08  
Operative note, 01/23/08  
History and Physical, 01/18/08  
Laboratory report 01/11/08  
Chest, Single View 01/11/08  
MRI scan of the left shoulder, 10/31/07  
Request for reconsideration, 04/16/08  
Therapy referrals, 03/17/08, 2/18/08, 1/28/08  
Preauthorization request  
Physical therapy progress notes, 03/13/08, 2/19/08, 2/1/08

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This is a female who was injured on xx/xx/xxxx and according to provided history, underwent a left shoulder arthroscopy and subacromial decompression for impingement syndrome on 01/24/08. Apparently she had been using her shoulder in a repetitive motion type activities, which resulted in her chief complaint. She has already had 24 postoperative physical therapy visits. The current request is for physical therapy 3 times a week for 3 weeks utilizing treatment methods 97110, 97140 and 97530.

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

Upon reviewing the provided medical records and ODG Guidelines the reviewer finds that the requested physical therapy for 3 times a week for 3 weeks utilizing treatments 97110, 97140 and 97530 is not medically necessary. This patient has already had 24 postoperative physical therapy sessions, which meet current guidelines after this type of surgery. She still has a significant gap between her active and passive range of motion, but the records do not reflect if a rotator cuff tear was part of this particular impingement syndrome. Based on the ODG Guidelines and the diagnoses submitted, further physical therapy in excess of the 24 visits as per ODG Disability and Treatment Guidelines is not 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 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)