

## Notice of Independent Review Decision

DATE OF REVIEW: 09/16/08

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of physical therapy at 2 times a week for 6 weeks for the left shoulder

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

### 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 or not medical necessity exists for each of the health care services in dispute.

It is determined that the 12 sessions of physical therapy at 2 times a week for 6 weeks for the left shoulder is not medically necessary to treat this patient's condition.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 09/03/08
- Adverse Determination Letter– 08/22/08, 08/29/08
- Notice of utilization review agent of assignment of IRO – 09/04/08

- Pre-Authorization Request Form – 08/18/08,08/22/08
- Therapy Referral/Hand Therapy Center – 08/14/08
- Initial evaluation by Dr.– 08/15/08
- Evaluation/office visit by Dr. – 08/04/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when his motorcycle was struck and he landed on the windshield of the other care on his left side. He sustained a fractured right femur and an ACL tear. The patient underwent an exchange nailing of the right femur on 04/02/08 and an arthroscopy of the left shoulder on 06/13/08. He has been receiving physical therapy for right lower extremity rehabilitation as well as left shoulder rehabilitation.

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

This patient has had at least 3 diagnoses for which physical therapy may or may not have been utilized. The medical records provided do not make it clear. The patient underwent a left shoulder arthroplasty on 06/13/08 and had physical therapy as part of his post-operative treatment. However, there is no specific documentation of the services provided or the number of sessions. Therefore, it is determined that the medical record documentation does not substantiate the medical necessity for the continued physical therapy.

**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)