

I-Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 3, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

PT 3 X 6 Right Shoulder, 97110, 97530

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

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

The reviewer finds that medical necessity does not exist for PT 3 X 6 Right Shoulder, 97110, 97530.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 7/1/08, 7/24/08

ODG Guidelines and Treatment Guidelines

Hospital, 6/26/08, 6/23/08, 7/21/08, 7/8/08

Orthopaedic Associates, 6/25/08, 7/16/08

PT, MS, CHT, 7/21/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a patient injured on xx/xx/xx. The patient has had a total shoulder replacement on the right. She has had at least 42 postoperative visits. She continues to have the same pain level of 0/10 at rest and 2/10 with motion. She has apparently, based on the medical records, documentation of brachial plexus injury, which either dates from the date of injury or from the surgical intervention. She continues to have improvement as well as compliance with a home exercise program.

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

The reviewer finds that medical necessity does not exist for PT 3 X 6 Right Shoulder, 97110, 97530. This patient has more than doubled the number of post-operative therapy sessions recommended in the ODG Guidelines. In addition, it is also documented that the patient's problem may be related to nerve injury. At this point the patient's nerve injury would not be improved by further physical therapy. Given the lack of substantiation for this degree of postoperative therapy, the previous adverse determination is being upheld.

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)