

Notice of Independent Review Decision

DATE OF REVIEW: 07/20/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 3x Wk x 4Wks Left shoulder 97110, 97112, 97150, 97530, 97535

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 physical therapy 3x Wk x 4Wks Left shoulder 97110, 97112, 97150, 97530, 97535 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 – 07/09/09
- Notification of Determination by – 06/22/09, 06/30/09

- Updated Plan of Progress for OT – 02/16/09, 04/20/09
- OT progress reports – 02/15/09 to 06/14/09
- Utilization Review Referral – 04/03/09, 05/05/09, 05/15/09
- Prescription for PT – 02/06/09, 03/19/09, 04/29/09, 06/08/09
- History sheet by Dr. – 03/18/08
- OT Weekly summary – 03/02/09 to 03/15/09
- Operative report for shoulder arthroscopy by Dr. – 01/07/09
- Office visit note by Dr. – 01/22/09 to 06/12/09

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx resulting in injury to the left shoulder. Arthroscopic surgery was performed, 01/07/09, on the left shoulder for subacromial decompression and distal clavicle resection for rotator cuff tendonitis and rotator cuff impingement syndrome. Post operatively the patient has received at least 36 sessions of physical therapy. He continues to complain of diminished range of motion and weakness. Recently, a request has been submitted for another 12 sessions of physical therapy.

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

The basis for prior denials has been that the patient received supervised physical therapy in excess of what is commonly felt to be an appropriate amount in the post operative period after arthroscopic subacromial decompression and distal clavicle resection for rotator cuff impingement syndrome. The prior denials were appropriate and should be upheld. The patient should be transitioned into a home program of exercises. Additional supervised physical therapy is unlikely to result in any significant benefit after the course of supervised physical therapy that has already been provided.

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)