



Notice of Independent Review Decision

**DATE OF REVIEW: 11/18/09**

**IRO CASE #:**

**NAME:**

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

Determine the appropriateness of the previously denied request for 9 sessions (3 times per week for 3 weeks) of physical therapy for the left shoulder to include CPT codes: 97116 - Gait training, 97110 - Therapeutic exercises, 97035 - Ultrasound 15 minutes, and G0283 - E-Stimulation.

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

Texas licensed 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 previously denied request for 9 sessions (3 times per week for 3 weeks) of physical therapy for the left shoulder to include CPT codes: 97116 - Gait training, 97110 - Therapeutic exercises, 97035 - Ultrasound 15 minutes, and G0283 - E-Stimulation.

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

- Notice of Utilization Review Findings dated 10/29/09.
- IRO Request Form dated 10/28/09.
- Request for A Review by an Independent Review Organization dated 10/27/09.
- Adverse Determination Letter dated 10/26/09, 10/23/09, 10/16/09.
- Pre-Authorization Request Form dated 10/19/09, 10/13/09.
- History/Re-Evaluation dated 10/13/09.
- Physical Evaluation Report dated 10/6/09.
- Medical Reports dated 11/12/09.
- Fax Cover Sheet/Comments dated 10/29/09.
- Disputed Issue Form dated 7/30/09, 3/25/09, 12/23/08.
- Report of Medical Evaluation dated 11/3/09, 9/15/09.
- Impairment Rating Report dated 11/3/09.
- Letter of Clarification dated 11/3/09, 10/30/09, 11/7/08.
- Medical Evaluation Report dated 9/16/09.
- Left Shoulder MRI dated 10/2/09.
- Meeting with Insurance Nurse dated 10/8/09.
- Workers Status Report dated 10/13/09, 8/14/09.
- Medical Record Review dated 8/16/09.
- PT Daily Progress Note dated 8/24/09, 8/22/09, 8/19/09, 8/17/09, 8/13/09, 8/3/09, 7/29/09, 6/29/09, 6/26/09, 6/19/09, 6/16/09, 5/20/09, 5/5/09,.
- Follow-Up Report dated 8/14/09.
- History/Examination Report dated 8/7/09.
- Texas Workers Compensation Report dated 7/16/09, 2/3/09.
- History of Current Condition dated 7/28/09, 7/10/09, 6/30/09, 3/26/09
- Patient Information Sheet dated 2/3/09.
- Evaluation of Patient dated 2/3/09, 1/13/09, 11/18/08.
- Shoulder Evaluation dated 8/26/09.

There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender: F**

**Date of Injury: xx/xx/xx**

**Mechanism of Injury: Fall**

**Diagnosis: Coracoclavicular ligament sprain.**

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

This female was injured, on xx/xx/xx. The patient fell and she sustained left shoulder injuries. The diagnosis was coracoclavicular ligament sprain. The patient initially was examined and then referred for physical therapy. The October

13, 2009 report stated that the patient attended 13 sessions of therapy along with Dr. injecting the shoulder on October 6, 2009. When seen on October 13, 2009, the physical therapy note indicated that the patient had continued left shoulder pain radiating into the left upper extremity but there had been a significant reduction in the pain level since the injection. There was limited motion and weakness of the shoulder with continued pain and the patient indicated that she dropped items at times. Objectively, there was tenderness generally along the deltoid, upper trapezius, supraspinatus sulcus, greater and lesser tuberosity, and intertubercular groove. Range of motion (ROM) was noted to be flexion 125/180 degrees, abduction 92/180 degrees, internal rotation 75/80 degrees, and external rotation 75/80 degrees compared to August 26, 2009 that noted flexion 90 degrees, abduction 85 degrees, internal and external rotation 70 degrees. Strength was 5/5. It was felt that the patient had improved with physical therapy but still had limited ROM and function. The Official Disability Guidelines set out the following: "Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks." Given that this injured individual has completed 13 physical therapy sessions to date, the aforementioned physical therapy recommendation has already been exceeded. Based thereon, the intervention in question would not be medically necessary. Accordingly, the previously denied determination is upheld.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 7<sup>th</sup> Edition (web), 2009, Shoulder – Physical therapy.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).