

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 sessions of aquatic therapy.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

The requested service, 12 sessions of aquatic therapy, is not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 11/4/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/17/10.
3. TDI Notice to IRO of Case Assignment dated 11/17/10.
4. Letters from DC dated 10/7/10 and 11/9/10.
5. Pre-Authorization Request dated 10/8/10.
6. Medical records from Spine and Rehab dated 11/10/10 and 8/24/10.
7. Chest x-ray dated 1/15/10.
8. MRI Right Shoulder dated 11/25/09.
9. Right Foot X-Ray dated 6/21/10.
10. Medical records from Medical Centers dated 7/26/10, 7/2/10, 6/28/10, 6/3/10, 4/8/10, 2/25/10, 1/15/10, 12/3/09, 11/12/09, 10/16/09, 9/17/09, 9/9/09, 8/28/09, and 8/21/09.
11. Progress reports from Group dated 6/30/10 and 2/9/10.
12. Denial documentation.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient underwent right shoulder arthroscopic repair of the superior labrum with anterior-posterior repair and acromioplasty on 1/21/10. The patient received 35 sessions of physical therapy post-operatively. On 8/24/10, the patient's provider noted the patient continued to have tenderness over the right deltoid, right supraspinatus, right subscapularis and right rhomboids. The provider noted the patient had not undergone treatment with injections. The provider has indicated that the patient had an exacerbation of his injury and continues to need supervised therapy to recover. The provider recommended aquatic therapy under direct supervision. Authorization was requested for coverage for 12 sessions of aquatic therapy. The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's shoulder pain.

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

I have determined that 12 sessions of aquatic therapy are not medically necessary for this patient. Official Disability Guidelines (ODG) for Surgery for a Rotator Cuff Tear and a SLAP (superior labrum from anterior to posterior) lesion make no mention of aquatic therapy as an appropriate or indicated treatment modality. Based on ODG Physical Therapy guidelines, the patient has exceeded the number of treatments that is recommended for the patient's injuries and diagnoses. The provider indicates the patient has experienced an exacerbation for which the patient requires additional therapy. There is no clinical justification supporting the necessity of aquatic therapy as opposed to other treatment modalities in this case.

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)