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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Jan/06/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2x4, 97110, 97035, 97140, G0283, 97535

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

M.D., Board Certified, Orthopedic Surgery

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

ODG Guidelines and Treatment Guidelines

Adverse Determination Letters, 12/1/09, 12/10/09

Letter from Patient 12/15/09

Physical Therapy Notes, 12/3/09, 11/23/09, 10/22/09, 9/23/09, 9/9/09

PATIENT CLINICAL HISTORY SUMMARY

The medical records presented for review begin with two separate non-certifications for additional physical therapy. There is a note from the injured worker stating why he believes the adverse determination is incorrect. The patient notes that he was originally misdiagnosed and that his injury was a rotator cuff tear requiring surgical intervention. Subsequent to this surgery, post-operative rehabilitation and physical therapy was delivered. The November 23, 2009 physical therapy assessment noted fairly good active range of motion and motor function. It is noted by the initial reviewer that the pain level was declared by the injured employee to be 1/10 and 3/10 with activity.

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

As per the ODG (updated December 18, 2009) post-operative physical therapy is recommended. {Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):Post-surgical treatment, arthroscopic: 24 visits over 14 weeks}. The issue becomes the efficacy, utility and reasonableness of improvement beyond that treatment point.

Therefore:

- A. When considering the range of motion reported by the physical therapy noted of November 2009; and
- B. The lack of any clear discussion as to why the remainder of the physical therapy protocol could not be continued in a home-based, self-directed exercise program emphasizing overall conditioning and fitness; and
- C. The lack of a physician assessment of the need for additional formal physical therapy; then, the reviewer finds that there is no clear convincing competent, objective and independently confirmable medical evidence presented to support the request made in this patient's case.

The number of physical therapy interventions as outlined by the ODG had been exceeded. The reviewer finds that medical necessity does not exist for Physical Therapy 2x4, 97110, 97035, 97140, G0283, 97535.

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

- ACOEM-AMERICA 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)