



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 10/28/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of Physical Therapy 3 x Wk x 4 Wks.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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 reviewer agrees with the previous adverse determination regarding prospective medical necessity of Physical Therapy 3 x Wk x 4 Wks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
These records consist of the following (duplicate records are only listed from one source): Records reviewed from: Pre-auth Worksheets – 9/14/10 & 9/28/10, Pre-auth Request – 9/13/10, Denial letters – 9/17/10 & 10/1/10; email to – 9/17/10; PTS Progress Re-Eval reports – 6/28/10-9/3/10, Patient Treatment Daysheet – 7/7/10-9/9/10; email to – 10/1/10; Review Med Pre-auth Request form Appeal – 9/13/10 & (7/7/10-9/9/10); MD letter – 9/24/10, and Office Notes – 3/23/10-9/10/10.

Records review from Physical Therapy Specialists: MD Operative Report – 4/5/10; MD MRI report – 3/3/10; PTS Flow Sheet – 6/18/10-9/9/10.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to available medical records, this worker was injured in a fall on ice on xx/xx/xx. Following the fall, he noted an inability to raise his left arm overhead when the arm was in an abducted position. This maneuver produced pain and he also had pain in the shoulder at night and with activity. It was noted that he had a history of a right rotator cuff tear with multiple surgeries and continued impairment of right shoulder function. X-rays of the left shoulder demonstrated a type III acromion and calcification of the coracoacromial ligament. An MRI study of the left shoulder showed acromioclavicular joint degenerative changes and complete tears of the supraspinatus and infraspinatus tendons with retraction of the muscle. The patient was evaluated by M.D. on March 23, 2010 and surgical repair was recommended.

On April 5, 2010, Dr. performed an arthroscopic subacromial decompression with resection of the anterior acromial spur and an arthroscopic repair of the supraspinatus tendon with three marginal convergence stitches and four anchors. Dr. continued to follow the patient in the postoperative period. His note of April 20 indicated that he had started therapy, but notes from physical therapist indicate that the formal therapy program began on or about May 25, 2010. According to available medical records, the patient underwent at least 37 physical therapy sessions between May 25, 2010 and September 3, 2010.

On September 10, 2010, Dr. noted that the patient was still having some pain after therapy, had good range of motion with 160° of flexion, and had shoulder strength of 4/5. Dr. note stated that he was doing better, "but still had a ways to go." He recommended and requested continued physical therapy three times a week for four weeks.

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

Records indicate that the patient had at least 37 physical therapy treatments between May 25, 2010 and September 3, 2010. Records indicate that during the last four weeks of therapy, some gains were made including 5° of abduction, 5° of external rotation, 10° of internal rotation, and one-half strength grade in shoulder flexion, internal rotation, and external rotation. Apparently, he was performing a home treatment program in addition to the formal therapy he was receiving.

ODG Guidelines recommend that individuals with surgical repair of a complete tear of the rotator cuff should receive 40 physical therapy visits over 16 weeks. An active self-directed home physical therapy program is recommended. This

gentleman received at least 37 and possibly more therapy sessions over the 14 weeks beginning on May 25, 2010, six weeks after his actual surgery. He made some progress during the last month of therapy, but still did not show normal strength or range of motion. ODG Guidelines recommend 40 physical therapy sessions following repair of a complete rupture of the rotator cuff. Twelve additional therapy sessions are not medically necessary according to information provided in the medical record and ODG Guidelines.

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)**