

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: November 2, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

An additional eight sessions of physical therapy two times per week for four weeks.

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)

An additional eight sessions of physical therapy two times per week for four weeks are 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.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 10-6/10.
3. TDI Notice of Assignment of Independent Review Organization dated 11/2/10.
4. TDI Notice to IRO of Case Assignment dated 11/2/10.
5. Operative Report dated 5/18/10.
6. Follow-up visits with MD dated 7/22/10 and 8/26/10
7. S.O.A.P Notes dated 6/18/10, 6/21/10, 6/22/10, 6/23/10, 6/28/10, 6/30/10, 7/2/10, 7/6/10, 7/7/10, 7/9/10, 7/12/10, 7/14/10, 7/16/10, 7/19/10, 7/26/10, 7/28/10, 7/30/10, 8/2/10, 8/4/10, 8/11/10, 8/16/10, 8/18/10, 8/20/10, 8/23/10 and 8/24/10.
8. Shoulder Re-Evaluation dated 7/14/10 and 8/13/10.
9. Denial Documentation.
10. ODG-TWC – Shoulder (Acute & Chronic).

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who has requested authorization for eight additional physical therapy sessions (two sessions per week over four weeks). The Carrier has denied this request indicating that the requested service is not medically necessary for treatment of the patient's shoulder pain.

The patient sustained an on-the-job injury to his left arm on xx/xx/xx. The patient reported hearing several pops and subsequently developed distal biceps pain. The provider reports that examination demonstrated pain with pronation and supination as well as some asymmetry of his biceps on the left versus the right. The patient also had weakness with elbow flexion and supination. The patient is status post surgical treatment (RC repair/acomioplasty) and has undergone a course of physical therapy (24 visits). He is seeking authorization for an additional eight sessions of physical therapy (two times per week for four weeks).

The Carrier indicates the requested service is not medically necessary as the patient has already exceeded guideline recommendations.

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

I have determined that an additional eight sessions of physical therapy (two sessions for four weeks) is not medically necessary for this patient. The submitted documentation demonstrates that the patient has already received 24 physical therapy sessions and reported being pain free for at least one month before completing the 24th session. He also reported that he was back to 85% of his pre-injury condition. His therapist recommended that he continue with an independent

program to gain additional strength at the 24th session. There is no indication of specific problems that need to be addressed and/or the need for additional therapies.

The Official Disability Guidelines (ODG) do not specifically address biceps tendon tear with surgical repair. However, there are ODG guidelines for shoulder sprain/strain and ODG guidelines for rotator cuff tear with surgical intervention and acromioplasty. The latter lists 24 treatments over 14 weeks as appropriate. It is medically reasonable to apply the rotator cuff tear/acromioplasty ODG guidelines to this case. As such, eight additional supervised therapy sessions are not consistent with ODG guidelines and are not medically necessary. The patient has had an adequate course of therapy to help him return to his maximum level of function.

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)