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Notice of Independent Review Decision

DATE OF REVIEW: 05/09/11
IRO CASE NO.:
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Item in dispute: Appeal for physical therapy x 12 visits, cpt codes not given

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME
Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. 12/21/10 - Clinical Note - Unspecified Provider
2. 12/29/10 - Telephone Encounter
3. 01/03/11 - Operative Report
4. 01/06/11 - Physical Therapy Note
5. 01/10/11 - Physical Therapy Note
6. 01/12/11 - Clinical Note - M.D.
7. 01/12/11 - Physical Therapy Note
8. 01/14/11 - Physical Therapy Note
9. 01/17/11 - Physical Therapy Note
10. 01/19/11 - Physical Therapy Note
11. 01/21/11 - Physical Therapy Note
12. 01/24/11 - Physical Therapy Note
13. 01/26/11 - Physical Therapy Note
14. 01/28/11 - Physical Therapy Note
15. 01/31/11 - Physical Therapy Note
16. 02/02/11 - Physical Therapy Note
17. 02/07/11 - Physical Therapy Note
18. 02/09/11 - Physical Therapy Note
19. 02/09/11 - Clinical Note - M.D.
20. 02/11/11 - Physical Therapy Note
21. 02/14/11 - Physical Therapy Note
22. 02/16/11 - Physical Therapy Note
23. 02/23/11 - Physical Therapy Note
24. 02/25/11 - Physical Therapy Note

25. 02/28/11 - Physical Therapy Note
26. 03/02/11 - Physical Therapy Note
27. 03/04/11 - Physical Therapy Note
28. 03/07/11 - Physical Therapy Note
29. 03/09/11 - Physical Therapy Note
30. 03/10/11 - Clinical Note - M.D.
31. 03/11/11 - Physical Therapy Note
32. 03/14/11 - Physical Therapy Note
33. 03/16/11 - Physical Therapy Note
34. 03/21/11 - Physical Therapy Note
35. 03/23/11 - Physical Therapy Note
36. 03/25/11 - Physical Therapy Note
37. 03/28/11 - Physical Therapy Note
38. 03/28/11 - Appeal Letter - P.T., CSCS
39. 03/29/11 - Case Management Report
40. 03/30/11 - Physical Therapy Note
41. 04/04/11 - Utilization Review
42. 04/11/11 - Physical Therapy Note
43. 04/12/11 - Letter - M.D.
44. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male who sustained an injury to the left shoulder on xx/xx/xx while lifting his luggage.

The employee saw Dr. on 12/21/10 with complaints of left shoulder pain. Physical examination revealed moderate tenderness to palpation of the anterior aspect of the left shoulder. There was no tenderness to palpation of the acromioclavicular joint. The biceps tendon was intact and stable. There was normal range of motion of the left shoulder and positive Hawkin's. There was pain with rotator cuff strength testing. Radiographs of the left shoulder demonstrated enlargement of the distal clavicle superior to the normal clavicle. There was a Type II acromial curve. There was some lipping of the inferior aspect of the glenoid, consistent with arthrosis. The employee was assessed with left shoulder pain and shoulder bursitis. The employee was prescribed ibuprofen 800 mg. The employee was recommended for MRI of the left shoulder.

A telephone call dated 12/29/10 stated an MRI of the left shoulder demonstrated abnormal signal within the rotator cuff, consistent with partial rotator cuff tear involving the subscapularis tendons, full thickness tear of the rotator cuff supraspinatus and infraspinatus tendons, arthrosis of the acromioclavicular joint, and complete biceps tendon tear. This report was not provided for review. The employee was recommended for surgical intervention.

The employee underwent arthroscopic rotator cuff repair, arthroscopic debridement, and arthroscopic subacromial decompression on 01/03/11.

The employee began physical therapy on 01/06/11.

The employee was seen for postoperative evaluation on 01/12/11. Physical examination revealed the wounds were clean and dry. The employee was recommended for continued physical therapy.

The employee saw Dr. on 02/09/11. Physical examination revealed good range of motion. The employee was recommended for continued physical therapy.

A physical therapy note dated 03/09/11 stated the employee was progressing nicely with mild capsular restrictions present at end range of motion. The employee was recommended for eight to twelve additional sessions of physical therapy.

The employee saw Dr. on 03/10/11. The note stated the employee was quite satisfied with his result. Physical examination revealed good range of motion. The employee was recommended for twelve additional sessions of physical therapy.

The request for twelve additional sessions of physical therapy was denied by utilization review on 04/04/11 due to no documentation of a focal neurological deficit in the affected upper extremity. For the described medical situation, the request for additional therapy services would exceed the amount recommended by the ***Official Disability Guidelines***. The employee completed thirty-three physical therapy sessions from 01/06/11 through 04/11/11. The note stated the employee reported a sharp pain in the shoulder every morning, but then felt fine for the remainder of the day with minimal discomfort. The employee also reported slight weakness.

Physical examination revealed active range of motion to be normal. The note stated the employee was progressing nicely with mild strength deficits. The employee was recommended for trial discontinuation with reevaluation in two weeks.

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

The requested 12 sessions of physical therapy are not recommended as medically necessary based on the clinical documentation provided. The employee has completed thirty-three sessions of physical therapy to date and does not currently exhibit any significant findings on physical examination that would be considered exceptional factors. Given the lack of any exceptional factors on physical examination, further formal physical therapy beyond the amount recommended in current evidence-based guidelines would not be supported. The employee has normal range of motion and no significant weakness. As there are no exceptional factors present on examination to support additional formal physical therapy, the requested 12 sessions are not medically necessary.

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

Official Disability Guidelines, Online Version, Shoulder Chapter

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks