

Notice of Independent Review Decision

DATE OF REVIEW: 1/27/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Aquatic Therapy 15 visits for the right shoulder 97110, 97112, 97530, 97036, 97140.

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. He is certified in pain management. He is a member of the Texas Medical Board. He has a private practice of Physical Medicine & Rehabilitation, Electrodiagnostic Medicine & Pain Management in Texas. He has published in medical journals. He is a member of his state and national medical societies.

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Based on documentation reviewed, it is my recommendation that the prior denial for noncertification of 15 sessions of aquatic therapy for the right shoulder be upheld.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records Received: 15 page fax 1/10/12 Texas Department of Insurance IRO request, 29 page fax 1/11/12 URA response to disputed services including administrative and medical records. 26 page fax 1/11/12 Provider response to disputed services including administrative and medical records. Dates of documents range from 10/24/07 (DOI) to 1/10/12

PATIENT CLINICAL HISTORY [SUMMARY]:

This man with a complete and retracted tear involving the right rotator cuff and who has undergone recent surgery with inability to sustain sufficient active motion of the joint. Patient date of birth age new patient initial evaluation. Chief complaint as of xx/xx/xx bilateral shoulder pain, right greater than left. The patient noted onset following an accident. He indicated that he had shoulder pain while reaching into the back seat of a car, putting on a seatbelt, washing car, adjusting the car mirror or radio, performing gardening or yard work, performing housework, vacuuming, pain at night, interfering with sleep, doing the laundry, starting a lawn mower, putting belt through belt loops, reaching for wallet, putting on a coat or sweater, combing or drying hair, lifting, pushing, or pulling, pouring tea or milk from a pitcher, typing or doing computer work, getting milk from refrigerator shelf, reaching overhead, reaching out to side, and carrying heavy objects. The patient reported to Dr. he had been seen and treated by his regular doctor, physical therapist, and orthopedic surgeon. The patient noted his pain was in relationship to an injury. He indicated he had had rotator cuff repair November 2009, which helped temporarily. MRI of the right shoulder dated 07/30/10 indicating a complete, full-thickness, recurrent tear of the supraspinatus tendon with approximately 4 cm of retraction. Mild fatty infiltration of the supraspinatus muscle belly. Focal full-thickness tear of the distal intraspinous tendon. 08/19/10 follow-up, Dr. noting continuation of symptoms and treatment plan indicating that the patient did not desire surgery and wanted further trial of physical therapy and injection and hydrotherapy. The patient was assessed of potential problems concerning his decision 11/30/10, noting the cortisone injection previously given relieved symptoms of pain and discomfort for a few months. The plan at that point was that the patient continued not to desire surgery, desired injection, and doing hydrotherapy on his own. Document, follow-up visit 02/10/11, indicating that prior injection had helped for a few days. The treatment plan indicated patient desired surgery and that the surgery recommended would be possible rotator cuff repair, arthroscopic subacromial decompression, arthroscopic debridement, irreparable rotator cuff tear, and arthroscopic biceps tenodesis. The patient was to be scheduled. 07/19/11, noting the patient experiencing no symptom change from prior visit. Also, patient desired surgery, and the surgery previously noted was recommended. Surgical operative report dated 11/11/11 with procedures indicated to include right shoulder examination, diagnostic glenohumeral arthroscopy, arthroscopic debridement of massive rotator cuff tear involving supraspinatus and infraspinatus, arthroscopic subacromial decompression with minimal

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acromioplasty and preservation of coraco-acromial ligament, and arthroscopic removal of foreign body. 11/17/11, patient follow-up noting the patient was postop with pain and movement consistent for recent surgery. There was no evidence of infection. The treatment plan was selective rest, hydrotherapy, activity modification, and follow-up in five weeks. Follow-up 12/15/11, indicating the patient's pain level was unchanged, motion unchanged, strength unchanged, no change in shoulder stability, and no change in shoulder function. The notation indicated that the patient needed aquatic therapy to resolve pseudo-paralysis. Notation that if unable to achieve active mobility with aquatic therapy, patient will require reverse shoulder prosthesis to achieve active mobility.

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

This man with a complete and retracted tear involving the right rotator cuff and who has undergone recent surgery with inability to sustain sufficient active motion of the joint and recommendation for aquatic therapy following apparent weakness after the recent surgery would reasonably, per the ODG, undergo standard physical therapy, including active assistive range of motion, strengthening exercises within range, utilization of electrical stimulation in order to assist improved function in the muscles post surgery. As the upper extremity cannot be effectively treated in an aquatic environment due to the depth and submerging of the total body part for reasonable benefit, aquatic therapy would not generally be considered treatment meeting ODG medical and necessary treatment criteria.

Aquatic therapy

Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. See the Low Back Chapter for more information and references. For recommendations on the number of supervised visits, see Physical therapy. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. (Tomas-Carus, 2007)

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)