SENT VIA EMAIL OR FAX ON
Jun/12/2012

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Jun/06/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 3 X wk X 4 wks

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
PM&R and Pain Medicine

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 04/11/12, 05/01/12
Certificate of medical necessity
Office visit note dated 03/13/12, 04/06/12, 01/26/12, 01/09/12, 10/05/11, 09/28/11, 07/04/11, 03/02/11, 01/11/10, 09/21/09, 08/31/09, 04/03/09, 01/21/09, 08/11/10, 09/17/10
Designated doctor evaluation dated 08/14/10
Physical therapy progress notes dated 02/03/09-09/21/10
Handwritten note dated 07/07/08
RME dated 03/12/09
MRI lumbar spine dated 08/07/08, 03/27/12
MRI right shoulder dated 08/07/08, 04/04/12, 03/15/11
MRI cervical spine dated 09/29/09
Radiographic report dated 09/14/09, 10/13/08, 08/31/09
Operative report dated 02/25/10

PATIENT CLINICAL HISTORY [SUMMARY]
The patient is a male whose date of injury is xx/xx/xx. On this date the patient was trying to move a tractor when the machine turned momentarily in reverse and he was thrown to the ground. The patient underwent rotator cuff repair of the right shoulder on 02/25/10. Designated doctor evaluation dated 08/14/10 indicates that the patient reached MMI as of 07/12/10 with 12% whole person impairment. MRI of the lumbar spine dated 03/27/12 revealed spondylolisthesis of L5 over S1, grade 1; degenerative disc disease at L5-S1 with bulging disc broad based and central that compromises the neural foramina bilaterally; minimal bulging disc at L3-4 and L4-5 with no significant compromise of the neural foramina. MRI of the right shoulder dated 04/04/12 revealed postoperative change; tendinosis/tendinopathy and tendinous strain of the proximal, mid and distal supraspinatus tendon associated with minimal fluid distributed within the subacromial and subdeltoid bursal spaces; type I-II acromion associated with subacute arthritic change of the AC joint proper without evidence for separation of the AC joint; effacement of the subacromial fat pad due to type II acromion and capsular hypertrophy of the AC joint. Physical examination on 04/06/12 notes lumbar range of motion is decreased due to spasm. Right shoulder has poor range of motion and tenderness to the AC area. The patient's gait is normal.

Initial request for physical therapy 3 x wk x 4 wks was non-certified on 04/11/12 noting that clarification regarding the total number of completed PT visits addressing the right shoulder and lumbar spine is needed. The most recent PT progress reports were not submitted for review. The PT treatment notes provided were dated 04/2010 and did not include objective measures of patient response to the rendered treatments. A more comprehensive physical examination of the right shoulder, lumbar spine and lower extremities with motor strength grading and range of motion measurements were not provided for review. The specific time-limited goals of the proposed treatment with objective measurable outcomes to monitor the patient's progress and to delineate the probable endpoint of care were not specified. Compliance with home exercises must be reviewed. Exceptional factors that would justify additional therapy treatments were not indicated. The denial was upheld on appeal dated 05/01/12 noting that the patient has completed an unknown number of physical therapy visits. The requesting provider was unable to update the medical records reviewed to address the issues raised by the initial denial. The medical records submitted for review did not contain a comprehensive account of the patient's physical examination with musculoskeletal findings such as motor strength and range of motion. The quantity of completed physical therapy visits was not mentioned to qualify the number of requested service. The number of requested physical therapy visits on top of the previously rendered service is in excess of the recommended service as per referenced guideline. There are no exceptional factors seen in the records that would necessitate an excess of physical therapy sessions as per referenced guideline.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION
Based on the clinical information provided, the request for physical therapy 3 x wk x 4 wks is not recommended as medically necessary, and the two previous denials are upheld. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. It is unclear how many sessions of physical therapy the patient has completed to date. There is no current, detailed physical examination submitted for review. There are no specific, time-limited treatment goals provided. The patient's compliance with an active home exercise program is not documented. Given the current clinical data, the requested physical therapy is not indicated as medically necessary.

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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES