

Core 400 LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions of Aquatic physical therapy for the right shoulder with the CPT codes #97113, #97110, #97140, #G0283

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

D.C., Board Certified Chiropractor

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 medical necessity exists for each health care service in dispute. It is the opinion of the reviewer that the requested 12 sessions of Aquatic physical therapy for the right shoulder with the CPT codes #97113, #97110, #97140, #G0283 cannot be supported as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Request for IRO 10/19/12
Request for IRO dated 10/16/12
Utilization review determination dated 09/11/12
Utilization review determination dated 09/21/12
MR arthrogram of right shoulder dated 06/15/12
Clinical note dated 07/12/12
Preauthorization report dated 07/17/12
Clinical note dated 09/04/12
Appeal of denial dated 09/18/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have date of injury of XXXXXX. The clinical records indicate the claimant has history of two prior surgeries of the shoulder. MR arthrogram performed on 06/14/12 notes a repeat rotator cuff repair with suture anchors seen in humeral head. There is a recurrent tear of majority of supraspinatus tendon with a few anterior fibers remaining attached. The infraspinatus tendon is likely torn as well as a small portion of the tendon posteriorly may still be attached. There is retraction of both tendons to level of glenohumeral joint. There is moderate subscapularis tendinopathy, which was worse

compared to prior study. There is evidence of biceps tenodesis. Humerus is high riding and nearly abuts the acromion. There is a large bony defect of greater tuberosity. There is moderate to severe atrophy of supraspinatus and infraspinatus muscles. Per clinical note dated 07/16/12 the claimant underwent a revision repair in 02/12. He has had postoperative physical therapy. He has pain with any active shoulder activities. He is unable to elevate arm to turn on the light switch. Current medications include Norco. On physical examination of the right shoulder, he has positive impingement signs with supraspinatus and infraspinatus weakness. He has tenderness over the rotator interval and deltoid insertion. He has well healed scars. He is noted to have active elevation to 70 degrees with passive elevation to 110. It is noted the claimant does not want to consider shoulder replacement. He is retired and plans on not carrying out any laboring activity. However, he would like pain relief and the ability to carry out simple daily activities.

The claimant was recommended to undergo revision rotator cuff repair, which was not approved under utilization review.

On 09/04/12 the claimant is reported to be status post 3 right shoulder surgeries to repair torn rotator cuff. He is noted to have participated in physical therapy but continues to have difficulty. Internal rotation was noted to be 80 degrees, abduction to 75, flexion to 90 and external rotation to 40. He subsequently was recommended to participate in aquatic therapy program.

The initial review was performed. Dr. notes the claimant has completed several sessions of therapy in the past and is unsure if additional therapy would result in significant clinical improvements. He further noted there is no documentation in the clinical rationale supporting office-based therapy over home program.

The appeal request was reviewed by Dr. on 09/21/12. Dr. non-certified the request noting that it is unclear as to what the clinical rationale is for aquatic therapy in this case as there is no indication for the need for reduced weight-bearing for shoulder rehabilitation. He further notes ODG does not support electrical stimulation in management of shoulder conditions. He notes ODG guidelines recommend the claimant undergo a trial.

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

The available medical record indicates the claimant has history of two prior shoulder surgeries secondary to work related injury. The records as presented suggest the claimant has undergone a third surgery, which appears to have been a salvage operation based on findings of MR arthrogram submitted for review. The records further suggest the claimant was initiated on course of postoperative physical therapy. The records as provided do not provide sufficient data regarding this treatment to justify the request for aquatic therapy. It would further be noted the record does not include a detailed note from the treating orthopedist with subsequent recommendation for participation in aquatic therapy program. Based on limited clinical information, it is the opinion of the reviewer that the requested 12 sessions of Aquatic physical therapy for the right shoulder with the CPT codes #97113, #97110, #97140, #G0283 cannot be supported as medically necessary, and the prior utilization review determinations are upheld.

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

ACOEM-AMERICA 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)