

Clear Resolutions Inc.

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Nov/25/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: additional PT 2x4 right shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

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 request for additional PT 2 x 4 right shoulder is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Utilization review determination dated 10/07/13, 10/11/13

Follow up note dated 09/27/13, 08/12/13, 06/26/13, 05/24/13, 05/10/13, 04/24/13, 04/01/13, 03/13/13, 10/18/13

Operative report dated 05/09/13

Handwritten daily note dated 10/07/13, 10/02/13, 09/30/13, 09/25/13, 09/23/13, 09/18/13, 09/16/13, 09/11/13, 09/09/13, 09/05/13, 08/07/13, 07/17/13, 06/24/13, 04/23/13, 03/27/13

Physical therapy plan of care dated 05/14/13

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. On this date the patient fell over a hula hoop, injuring her right shoulder. The patient underwent right shoulder arthroscopy with rotator cuff repair, acromioplasty, biceps tenotomy and debridement on 05/09/13. The patient has been authorized for 44 postoperative physical therapy visits to date. Per note dated 09/27/13, she states she is doing really well; she had been going to physical therapy and noted improvement in her activities and range of motion. She only has a little soreness with bad weather. Note dated 10/18/13 indicates that she continue to do a home exercise program. She finished physical therapy about a week ago. She states she only has some tightness at terminal movements. On physical examination sensation is intact. Strength is rated as 5/5. Hawkins, Neer, Gerber and O'Brien are negative. Range of motion is forward flexion 170, abduction 160, external rotation 60 with elbow at side and internal rotation to approximately L4.

Initial request for additional PT 2 x 4 right shoulder was non-certified on 10/07/13 noting that the claimant has had 44 visits of PT. The evidence based guidelines recommend transition to a home exercise program. There are no medical records with exam, deficits, objective assessment of response to TP from the treating provider. Therefore, the request exceeds

evidence based guidelines. The denial was upheld on appeal dated 10/11/13 noting that there was no documentation of exceptional indications for therapy extension and reasons why a prescribed independent home exercise program would be insufficient to address any remaining functional deficits.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient underwent right shoulder arthroscopy with rotator cuff repair, acromioplasty, biceps tenotomy and debridement on 05/09/13 and has been authorized for 44 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 24 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. Note dated 10/18/13 indicates that she continue to do a home exercise program. She states she only has some tightness at terminal movements. On physical examination sensation is intact. Strength is rated as 5/5. Hawkins, Neer, Gerber and O'Brien are negative. Range of motion is forward flexion 170, abduction 160, external rotation 60 with elbow at side and internal rotation to approximately L4. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for additional PT 2 x 4 right shoulder is not recommended as medically necessary.

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)