

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Apr/17/2013

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** additional PT 3xwk x 4wks right shoulder 97035, 97110, 97112, 97140, G0283

**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.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines

Office note dated 01/14/13, 02/04/13, 12/21/12, 12/26/12, 11/07/12, 11/09/12, 10/05/12, 10/08/12, 08/31/12, 08/30/12, 07/09/12, 07/18/12

History and physical exam dated 04/01/13, 02/04/13, 12/28/12, 12/19/12, 12/17/12, 12/14/12, 12/12/12, 12/10/12, 12/07/12, 12/05/12

Letter dated 11/09/12

Functional capacity evaluation dated 01/24/13

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a male whose date of injury is xx/xx/xx. On this date the patient slipped on ice at work and landed on the right upper extremity. The patient is noted to be status post revision right shoulder rotator cuff repair performed on 06/07/12 followed by 49 postoperative physical therapy visits to date. Note dated 11/09/12 indicates that the patient is recovering more slowly than anticipated. Follow up note dated 01/14/13 indicates that the patient is recovering poorly. Shoulder range of motion is ER 80, IR 85, active humeral flexion 145, active humeral abduction 130. There is no instability, anterior, posterior, inferior and no subluxation. Shoulder strength is slightly decreased and moderately decreased. Neer impingement sign is mildly positive. Hawkins impingement sign is negative. Cross body AC compression test is negative. Speed's test is mildly positive. Functional capacity evaluation dated 01/24/13 indicates that the patient is currently working without restrictions. Required PDL is sedentary. The patient is limited in all functional activities involving overhead movement. Follow up note dated 02/04/13 indicates that the shoulder has no deformity and soft tissue swelling. Shoulder range of motion is unchanged.

Initial request for additional physical therapy was non-certified on 02/07/13 noting that the patient has had 49 sessions of PT post-op. From the submitted clinicals it appears that his response to PT has plateaued and reached a steady state. Any request for additional PT

exceeds the established guidelines. The denial was upheld on appeal dated 03/12/13 noting that patient has qualified for heavy lifting on functional capacity evaluation, but was told that he should only perform medium-heavy lifting to prevent re-injury. There was 145 of active flexion and 170 of passive flexion. There has not been any significant improvement in exam findings with continued supervised PT. There are no objective signs of improvement. Patient has had 49 visits of PT. The patient should be well-versed in a home exercise program after 49 visits of supervised PT. There was a revision cuff repair. The patient may benefit from permanent restrictions.

History and physical exam dated 04/01/13 indicates that the patient is recovering well and no change since last visit. The patient is doing well. On physical examination the shoulder has no soft tissue swelling, ecchymosis and skin lesions or rash. There is mild tenderness present at the posterolateral corner of the acromion. Range of motion is unchanged. Overall, there is no instability, anterior, posterior, and inferior; no AC elevation and no subluxation. Shoulder strength is moderately decreased.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient is status post revision right shoulder rotator cuff repair performed on 06/07/12 followed by 49 postoperative physical therapy visits to date. The Official Disability Guidelines support up to 24-30 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. The submitted records indicate that the patient has plateaued in therapy. The patient is currently working without restrictions. 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 3xwk x 4wks right shoulder 97035, 97110, 97112, 97140, G0283 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)