

**MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: January 7, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy for the left shoulder – 12 additional visits.

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

P.T., Certified in Orthopedic Physical Therapy.

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)

The requested physical therapy for the left shoulder – 12 additional visits is not medically necessary for treatment of the patient’s medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 12/3/12.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) 12/18/12.
3. Notice of Case Assignment dated 12/18/12.
4. Prescription for Rehabilitation Services dated 7/24/12.
5. Rehabilitation Ongoing Plan of Care dated 8/28/12, and 7/31/12.
6. Denial documentation dated 12/14/12, 11/16/12, 9/5/12, and 8/6/12.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reportedly sustained an injury. A physical therapy note dated 7/31/12 documented that the patient had completed 34 sessions of treatment. The patient complained of shoulder pain. Physical examination revealed 143 degrees of left shoulder forward flexion and 180 degrees of abduction in supine position. While standing, the patient had 60 degrees of forward flexion, and 70 degrees of abduction. The patient was noted to have 3/5 left shoulder flexion and abduction motor strength. The patient was recommended for continued therapy three times per week for four weeks. A follow-up therapy note on 8/28/12 reported the patient complained of 4/10 pain. Physical examination revealed 100 degrees of forward flexion in standing, 153 degrees of forward flexion in supine, and 70 degrees of abduction. The patient had 3+/5 motor strength. The patient was again recommended for continued therapy three times per week for four weeks.

The URA denied the request for physical therapy on 11/13/12 indicating that additional physical therapy was non-certified due to no recent range of motion or updated notes after recent authorized sessions. On 12/14/12, the URA reported that the request for therapy was again non-certified as the provider acknowledged that the patient had plateaued and was a candidate to transition to a home exercise program.

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

Applying the Official Disability Guidelines (ODG) for physical therapy, treatment should allow for fading of treatment frequency (from up to three visits per week, to one visit per week, or less), plus active self-directed home physical therapy. Thus, this patient’s request for physical therapy for the left shoulder is not medically necessary based on ODG criteria. The patient has undergone approximately 38 sessions of physical therapy. The records note that the patient’s treating provider has indicated that the patient has plateaued. All told, the patient has completed sufficient formal physical therapy and should be capable of continuing to improve with a home

exercise program. The request for additional physical therapy combined with prior sessions exceeds the support in evidence-based guidelines for total duration of care. There are no exceptional factors to warrant continuation of formal physical therapy versus a home exercise program. As such, the requested physical therapy is not medically necessary for treatment of this patient's medical condition.

Therefore, I have determined the requested physical therapy for the left shoulder – 12 additional visits, is not medically necessary for treatment of the patient's medical condition.

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 JUDGMENT, 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)**