



Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 8/6/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

The item in dispute is the prospective medical necessity of PT 2-3 x 6 for the right shoulder.

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

The reviewer is a Medical Doctor who is board certified in 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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of PT 2-3 x 6 for the right shoulder.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was noted to have tripped at work and landed on her right shoulder. Records from the treating provider from the spring of 2014 revealed that there was persistent shoulder pain with tenderness of the AC joint and the bicipital groove. There was "good strength but decreased range of motion. Therapy was recommended. On July 16, 2014 was noted that there was "decreased" shoulder motion. Muscle strength was noted to be graded 5/5. Medications have included Flexeril. A shoulder MRI from June 6, 2014 was noted to reveal a full thickness tear of the rotator cuff with retraction along with synovitis and glenohumeral chondromalacia. The biceps tendon was noted to be subluxated and there was tendinosis. There was also the degeneration of the labrum with a possible labral tear. Records from June 10, 2014 revealed "she has not had treatment since."

Passive range of motion was noted to be within normal limits with complaints of pain at the end range of motion. There were no complaints of pain with palpation over the SS tendon. The impression by the therapist was that of rotator cuff tendinitis with pain and decreased range of motion. Denial letters have revealed the lack of clarity of the number of therapy treatment sessions that have been provided recently.

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

The most recent records have not specifically delineated detailed range of motion findings of the shoulder. In addition, it is unclear as to how many visits of physical therapy have been provided to date as only one of those records were evident. The lack of detail and clarity as documented does not support the request as being medically reasonable and-or necessary, per applicable evidence-based criteria referenced below.

ODG Shoulder Chapter: Physical Therapy- ODG Physical Therapy Guidelines – Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Rotator cuff syndrome/impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

Complete rupture of rotator cuff (ICD9 727.61; 727.6)

Post-surgical treatment: 40 visits over 16 weeks

Adhesive capsulitis (IC9 726.0):

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Medical treatment, partial tear: 20 visits over 10 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

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 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)**