

IRO NOTICE OF DECISION – WC



Notice of Independent Review Decision

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August 6, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT 2 x 4 (8 visits) left shoulder; CPT codes 97110, 97530, G02838, 97140

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

American Board of Orthopaedic 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 of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

Physical Therapy from 5-30-14 (1 visit)

6-16-14, performed a Peer Review. It was his opinion that the request for additional physical therapy of the left shoulder is not medically necessary. There are physical therapy notes for review with an operative note and preoperative note. There have been 22 visits of physical therapy to date. The claimant should be able to be transitioned to a home exercise program. There are no postoperative medical records with examinations, noted deficits or clinical rationale for additional supervised physical therapy from the AP. An updated exam to determine the next step in management is recommended. Furthermore, the request exceeds the recommendations of the evidence-based guidelines. Therefore, the request for additional physical therapy of the left shoulder is not medically necessary.

6-23-14, performed a Peer Review. It was his opinion that the request for physical therapy for the left shoulder is not medically necessary. Per 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 physical therapy. Also see other general guidelines that apply to all conditions under physical therapy in the ODG Preface." The Guidance criteria have not been met. The claimant has had 22 documented physical therapy visits. In addition, non-applicability to a prescribed and self-administered therapy protocol has not been documented. Therefore, the additional 8 visits are not indicated as medically necessary at this time.

7-5-14 the claimant states he received the letter denying physical therapy and he disagrees.

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

Medical records reflect his claimant is status post left shoulder arthroscopic subacromial decompression, distal clavicle excision and bursectomy with proximal biceps tenodesis and subpectoral biceps button. The claimant has had 22 postop physical therapy sessions. Regarding the request for physical therapy 2 x 4 (8 visits) left shoulder, current treatment guidelines support up to 24 physical therapy sessions post arthroscopy. Based on the records provided, partial certification is provided for physical therapy x 2 sessions in order to allow the claimant to complete physical therapy per ODG and transition the claimant to a home exercise program.

ODG 2014 PHYSICAL THERAPY:

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

IRO REVIEWER REPORT - WC

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)