

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/28/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 sessions physical therapy three times a week for four weeks

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

PM&R

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

MRI left shoulder 11/01/13

Clinical record 11/06/13

Clinical record 12/04/13

Clinical record 12/09/13

Clinical record 12/20/13

Clinical record 01/07/14

Utilization review reports 12/13/13 and 12/26/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. The patient developed complaints of pain in the neck shoulder and left arm. Treatment included physical medications including hydrocodone and Flexeril. MRI of the left shoulder from 11/01/13 showed tendinopathy of the rotator cuff with degenerative joint changes. Initial physical examination from 11/06/13 showed positive impingement signs for the left shoulder. No specific mechanism or range of motion measurements were reported. The patient had a steroid injection on this date. Follow up on 12/04/13 indicated the patient had moderate improvement with injections. The patient had been attending physical therapy. Physical therapy report from 12/09/13 indicated the patient completed 10 sessions of physical therapy. Objective exam demonstrated mild straight mild weakness in the left shoulder with range of motion testing. Range of motion was improved to 145 degrees flexion 35 degrees extension 120 degrees abduction and 45 degrees external rotation. Internal rotation was at 65 degrees. The patient was

recommended to continue with physical therapy to improve range of motion and strength. As of 01/07/14 the patient continued to have localized symptoms in the left base of the cervical spine and trapezius. Physical examination demonstrated good strength in the left shoulder with external rotation limited to 70 degrees. The requested 12 additional sessions of physical therapy were not recommended as medically necessary by utilization review on 12/13/13 as the requested amount of sessions exceeded guideline recommendations and there was limited recommendation for passive modalities including electrical stimulation. The request was again non-certified by utilization review on 12/26/13 as there was no documentation regarding compliance with physical therapy or home exercise program. There was also limited finding supporting ongoing physical therapy in excess of guideline recommendations. There was also no recommendation in the guidelines for passive modalities such as electrical stimulation.

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

The patient has been followed for ongoing complaints of left shoulder pain and pain in the base of the neck and left trapezius. The last physical therapy assessment from 12/13 showed continuing loss of range of motion in the left shoulder and some continuing weakness. As of the most recent assessment from 01/14 there was good intact strength in the left shoulder with very limited external rotation very mildly limit at very with a very mild limitation in external rotation. These findings alone do not support continued physical therapy beyond the maximum recommended in current evidence based guidelines. Per guidelines there should be evidence of exceptional factors to support ongoing physical therapy outside of guideline recommendations. Objective findings could be reasonably addressed with a continuation of self-directed home exercise program, as the guidelines recommend, and would not reasonably require further formal physical therapy. Therefore, this it is the opinion of this reviewer that medical necessity in this case is not established and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES