



Notice of Independent Review Decision - WC

DATE OF REVIEW: 06/12/14

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Eight Sessions of Physical Therapy for the left shoulder

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

Board Certified in Physical Medicine and Rehabilitation

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 or not medical necessity exists for each of the health care services in dispute.

Eight Sessions of Physical Therapy for the left shoulder - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The records available for review indicate that on the date of injury, the claimant developed symptoms of pain in the left shoulder.

The claimant was evaluated on xxxxx. On this date, there was documentation of a positive Hawkins sign in the left shoulder. There was weakness with testing of the rotator

cuff musculature in the left upper extremity. It was recommended that a left shoulder MRI scan be accomplished.

A left shoulder MRI scan was obtained on 01/28/14. This study revealed findings consistent with the presence of a small acromioclavicular joint effusion, as well as evidence of an acromioclavicular joint hypertrophy. There was evidence for a Type II lateral downsloping acromion with an acute partial tear of the infraspinatus tendon. There was evidence for full thickness tearing of the posterior supraspinatus, as well. There was evidence of a SLAP type labral tear, as well, with an intact biceps anchor. It was noted that previous treatment to the left shoulder did include a surgical procedure to the left shoulder.

The claimant was re-evaluated on 01/31/14 at which time it was recommended that consideration be given for treatment in the form of surgical intervention to the left shoulder.

On 02/11/14, surgery was performed to the left shoulder in the form of an arthroscopic subacromial decompression, a left shoulder mini-open rotator cuff repair, and a left shoulder labral debridement.

re-assessed the claimant on 02/13/14. On that date, it was noted that the surgical site was well healed.

A document dated 02/18/14, indicated that the claimant had commenced treatment in the form of physical therapy services.

evaluated the claimant on 03/03/14 at which time it was recommended that the claimant continue access to treatment in the form of physical therapy services.

A medical document dated 03/07/14, indicated that the claimant had received seven sessions of physical therapy services.

evaluated the claimant on 03/24/14. On this date, it was recommended that the claimant commence weaning out of a sling on the left shoulder.

A medical document dated 03/31/14, indicated that the claimant had received seventeen sessions of physical therapy services to the left shoulder.

A medical document dated 04/24/14, indicated that the claimant had received 27 sessions of physical therapy services. On this date, it was documented that the claimant was a participant in a home exercise regimen. Objectively, it was documented that there was an ability to flex the left shoulder 159 degrees. There was documentation of ability to externally rotate the left shoulder 52 degrees.

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

Based upon the medical documentation presently available for review, the Official Disability Guidelines would not support a medical necessity for additional treatment in the form of physical therapy services to the left shoulder. The records available for review indicate that since surgery was performed to the affected shoulder, the claimant has received at least 27 sessions of physical therapy services. For the described medical situation, the above noted reference (ODG) would support an expectation for an ability to perform a proper non-supervised rehabilitation regimen (HEP) when an individual has received the amount of supervised rehabilitation services previously provided. As such, based upon the records available for review, the Official Disability Guidelines would not support a medical necessity for treatment in the form of physical therapy services for the described medical situation.

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

- MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**