

MAXIMUS Federal Services, Inc.
4000 IH 35 South, (8th Floor) 850Q
Austin, TX 78704
Tel: 512-800-3515 ♦ Fax: 1-877-380-6702

Notice of Independent Review Decision

DATE OF REVIEW: September 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy x 6, 3 x 2 weeks, left shoulder, CPT codes 97110, 97112, 97530 and 97140.

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

M.D., 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)

I have determined that the requested physical therapy x 6, 3 x 2 weeks, left shoulder, CPT codes 97110, 97112, 97530 and 97140 is medically necessary for the treatment of the patient's medical condition.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury on xx/xx/xx. He underwent open reduction and internal fixation of a glenoid fracture on 10/31/13. This was followed by postoperative physical therapy. On 7/14/14, physical therapy daily notes documented that the patient tolerated therapy well, and continued therapy was recommended. The patient was evaluated on 7/30/14. Physical findings included tenderness of the left shoulder with a reduction in range of motion, unchanged from the previous visit. The patient had pain complaints of 4/10 to 5/10. The records noted that the patient had not made any progress with physical therapy until he switched physical

therapists. A request has been submitted for physical therapy x 6, 3 x 2 weeks, left shoulder, CPT codes 97110, 97112, 97530 and 97140.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Specifically, the initial denial indicated that documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. The initial denial also noted that a valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the submitted records. On appeal, the URA indicated that the patient should be able to transition to a home exercise program, and the request exceeds evidence-based guidelines.

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

The submitted documentation indicates that this patient has participated in 40 visits of physical therapy. However, the prescribing physician notes that the patient has changed providers during physical therapy due to a lack of progress made with the initial physical therapy provider. It is noted that the patient has participated in 12 visits of physical therapy with the new provider and has made progress with decreased pain complaints and increased functionality. The Official Disability Guidelines recommend 24 visits of physical therapy as appropriate treatment in this clinical situation. However, due to a change in provider, the patient has only had 12 visits of physical therapy with progression and reduction in pain and increased functionality. The lack of results achieved from the patient's initial physical therapy provider is an exceptional factor and warrants deviation from the guidelines in this particular case. Six additional visits of physical therapy for the left shoulder would allow the current provider to address remaining deficits and transition the patient into an effective home exercise program. Thus, physical therapy x 6, 3 x 2 weeks, left shoulder, CPT codes 97110, 97112, 97530 and 97140 is medically indicated for the treatment of this patient.

Therefore, I have determined the requested physical therapy x 6, 3 x 2 weeks, left shoulder, CPT codes 97110, 97112, 97530 and 97140 is 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)