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Notice of Independent Review Decision

DATE OF REVIEW: 8/12/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 Physical Therapy visits for the left shoulder between 7/10/2015-9/08/2015.

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

M.D. Board Certified in Occupational Medicine.

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)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who has filed a claim for chronic neck and shoulder pain reportedly associated with an industrial injury of xx/xx/xx. In a Utilization Review report dated June 23, 2015, the claims administrator denied a request for 12 sessions of physical therapy for the left shoulder. The claims administrator stated that the applicant had undergone an earlier left rotator cuff repair surgery on March 20, 2015. The claims administrator stated that attending provider had failed to outline how much prior physical therapy the applicant had had and/or whether the applicant had benefitted from the same. The applicant and/or attending provider appealed further.

In a July 16, 2015 Utilization Review report, the claims administrator upheld the previous denial, stating that the applicant had completed a total of 24 sessions of postoperative physical therapy following an earlier rotator cuff revision procedure of March 20, 2015.

The claims administrator again stated that the attending provider failed to outline whether the applicant had progressed functionally with physical therapy.

In a June 18, 2015 progress note, the applicant reported ongoing complaints of shoulder and neck pain status post earlier rotator cuff repair surgery. It was reported that the applicant had residual cervical radicular pain complaints. The applicant was on Norco and Mobic for pain relief. It was reported that the applicant had undergone a shoulder arthroscopy revision rotator cuff repair procedure, debridement, lysis of adhesions, subacromial decompression, and distal claviclectomy surgery. The revision study had transpired on March 20, 2015 while the first surgery had taken place on June 3, 2014. The applicant exhibited 170 degrees of shoulder range of motion with good strength appreciated. A Medrol Dosepak was prescribed



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for residual cervical radicular complaints. The applicant was kept off of work and asked to follow up with a spine doctor for his cervical radicular pain complaints. There was no mention of the need for further physical therapy involving the shoulder on this date.

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

Per ODG references, the requested "12 Physical Therapy visits for the left shoulder between 7/10/2015-9/08/2015" are not medically necessary. The applicant had had prior treatment (24 sessions) seemingly consistent with the 24-session course suggested in ODG's Shoulder Chapter Physical Therapy Guidelines as part of postsurgical treatment following arthroscopic shoulder surgery, as transpired here. ODG also suggests tapering or fading the frequency of treatment over time and transitioning the applicant toward self-directed home-based physical therapy. Here, the most recent progress note of June 18, 2015 suggested the applicant had a near-full recovery following earlier shoulder surgery of March 20, 2015. The applicant was described as feeling "much better" at that time. The applicant's incision was completely healed. Near normal shoulder range of motion to 170 degrees of flexion was appreciated, with good strength appreciated on that date. All information on file, thus, pointed to the applicant's having effected a near full recovery following earlier shoulder surgery. It appears, thus, the applicant was capable of transitioning to self-directed home-based physical medicine, as suggested by ODG, without the lengthy formal course of physical therapy at issue. Therefore, the request is not medically necessary.

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

- 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