

**Applied Assessments LLC**  
**An Independent Review Organization**

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**Notice of Independent Review Decision**

**Review Outcome:**

**A description of the qualifications for each physician or other health care provider who reviewed the decision:**

Orthopedic Surgery

**Description of the service or services in dispute:**

Physical Therapy 3 X 3 wks right shoulder

**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 whose date of injury is xx/xx/xx. The patient was lowering a tailgate on the back of a truck when he felt a pop in the right shoulder. He is noted to be status post prior rotator cuff repair in 1989. MRI of the right shoulder dated 04/09/14 revealed complete full thickness tears of the supraspinatus tendon with 5 cm of medial tendon retraction and moderate to severe muscular atrophy; extensive full thickness tears of the subscapularis and infraspinatus tendons moderate to severe muscular atrophy and associated tendon retraction; and AC osteoarthritis. The patient underwent right shoulder arthroscopic rotator cuff repair, subacromial decompression and biceps tenotomy on 05/22/14. Re-evaluation dated 10/16/14 indicates that the patient has completed 36 postoperative physical therapy visits to date. Office visit note dated 10/31/14 indicates that current medications are lisinopril, allopurinol, atenolol, ciprofloxacin, Crestor, glyburide, metformin, nitrostat, oxybutynin chloride, and promethazine. On physical examination there is no erythema, ecchymosis, swelling or atrophy of the right shoulder. Strength is 4+/5 supraspinatus, 4/5 infraspinatus and 5/5 subscapularis. Active range of motion is flexion 165, external rotation 20, internal rotation to L2. Neer and Hawkins signs are negative. O'Brien's, Mayo Shear, Speed and Yergason testing is negative. Re-evaluation dated 12/17/14 indicates that the patient reports he did not have any pain after his surgery and is currently off all pain medications. Follow up note dated 12/31/14 indicates that medications are unchanged. Physical examination is unchanged with the exception of internal rotation to T12.

Initial request for physical therapy 3 x 3 weeks right shoulder was non-certified on 10/24/14 noting that the claimant has completed what should have been a sufficient number of visits of postoperative PT and there is no clinical evidence that he remains unable to continue and complete his rehab with an independent home exercise program. There is no indication that continuation of supervised exercises is likely to provide him with significant or sustained benefit that he cannot achieve on his own. The denial was upheld on appeal dated 12/05/14 noting that there was no recent exam by the treating doctor to assess current deficits or clinical rationale for additional supervised physical therapy. The patient had completed 36 prior postoperative physical therapy sessions. The patient used an abduction sling. The patient should be transitioned to a home exercise program. The request exceeds evidence based guidelines.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The patient underwent right shoulder arthroscopic rotator cuff repair, subacromial decompression and biceps tenotomy on 05/22/14 and has completed 37 postoperative physical therapy visits to date, per discharge summary dated 12/17/14. The Official Disability Guidelines support up to 24 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support continuing to exceed this recommendation. There are no exceptional factors of delayed recovery documented. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. As such, it is the opinion of the reviewer that the request for physical therapy 3 x 3 wks right shoulder is not recommended as medically necessary.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ACOEM-America College of Occupational and Environmental Medicine um
- knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and 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 and Treatment
- Guidelines Pressley Reed, the Medical Disability Advisor
- Texas Guidelines for Chiropractic Quality Assurance and Practice
- Parameters Texas TACADA Guidelines

- TMF Screening Criteria Manual
- Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)