



## **IRO REVIEWER REPORT – WC**

**DATE OF REVIEW:** 06/02/15

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical Therapy 2xWk x 6 Wks, Right 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:**

- Physical Therapy 2xWk x 6 Wks, Right Shoulder - Upheld

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The date of injury is listed as xx/xx/xx. The records available for review indicate that on the date of injury the claimant was attempting to transfer a x and the x pulled on the right upper extremity of the claimant. After this event occurred, the claimant developed symptoms of pain in the right shoulder region.

The records available for review indicate that on 12/08/14 the claimant was evaluated. On this date, it was recommended that a right shoulder MRI scan be accomplished.

On 12/12/14, a right shoulder MRI scan was obtained. This study revealed findings consistent with a moderate to high grade partial thickness intrasubstance tear of the mid and posterior fibers of the supraspinatus tendon and the anterior fibers of the infraspinatus tendon. There was evidence for mild suprascapular tendinosis with mild intraarticular long head biceps tendinosis.

It is documented that the claimant received a session of physical therapy at on 12/16/14.

The claimant was evaluated on 12/16/14. On this date, this physician recommended that a cervical MRI scan be accomplished.

The claimant was re-evaluated on 12/19/14. On this date, it was recommended that the claimant receive access to treatment in the form of physical therapy. A therapeutic injection to the subacromial bursa of the right shoulder was provided on this date. This physician indicated that the claimant would likely require surgical intervention to the right shoulder.

The claimant was evaluated on 01/16/15. On this date, it was documented that a cervical MRI scan was obtained on 01/13/15. This study reportedly revealed findings consistent with mild multilevel degenerative disc and facet joint changes of the cervical spine. There was a small broad posterior disc osteophyte complex at the C5-C6 level with no evidence of a disc herniation.

The records available for review indicate that surgery was performed to the right shoulder on 02/03/15. Surgery consisted of a right shoulder arthroscopy, subacromial decompression, and rotator cuff repair.

It is documented that the claimant received a session of physical therapy on 03/31/15. On this date, there was documentation of an ability to flex the right shoulder 105 degrees and abduct the right shoulder 65 degrees. There was documentation of approximately 3/5 strength with flexion and abduction of the right shoulder.

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

For the described medical situation, as a general rule, Official Disability Guidelines would support up to 24 sessions of physical therapy services in the postoperative interval in an effort to maximize recovery from surgical intervention to the affected shoulder and in an effort to fully educate an individual on a proper nonsupervised rehabilitation regimen. The records available for review indicate that surgery was performed to the right shoulder on 02/03/15. The records available for review do not indicate the number of physical therapy sessions that the claimant has previously received. As such, based upon the medical documentation currently available for review, medical necessity for twelve sessions of physical therapy is presently not established, given the fact that specifics are not provided with regard to the amount of physical therapy services previously provided. Consequently, based upon the medical documentation available for

review, medical necessity for twelve visits of physical therapy, as requested, is not presently established for the described medical situation at this time.

**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**