

Clear Resolutions Inc.

An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Apr/15/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Continued physical therapy 3 x a week x 4 weeks

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: DO, Board Certified Orthopedic Surgery

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 medical necessity exists for each health care service in dispute. it is this reviewer's opinion that medical necessity for continued physical therapy 3 x a week x 4 weeks is established

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who was injured on XX/XXXX on XX/XX/XX while cutting a log. The patient described feeling a pop in the right shoulder and had difficulty with range of motion. Prior MRI studies noted partial thickness tearing at the subscapularis with subluxation of the biceps tendon. The patient underwent rotator cuff debridement and repair followed by subacromial decompression and labral debridement on XX/XX/XX. The patient completed 23 sessions of physical therapy through XX/XX/XX.

The XX/XX/XX clinical physical therapy record noted the patient had full compliance and participation during therapy. There was noted loss of range of motion at 105 degrees flexion with 115 15 degrees of abduction. External rotation was 32 degrees. There was continued mild to moderate weakness in the right shoulder with flexion and abduction. It was recommended that the patient continue with additional physical therapy due to continuing loss of range of motion and weakness. The patient had met none of the short term or long term goals but was making progression towards goal completion. The additional physical therapy requested was denied by utilization review on XX/XX/XX as the number of sessions exceeded the amount recommended by guidelines. The request was again denied on XX/XX/XX as there was no rationale to support exceeding guideline recommendations.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The clinical records submitted for review noted 23 sessions of physical therapy following a rotator cuff repair and debridement as well as a subacromial decompression and labral repair. These multiple procedures would reasonably require more physical therapy than the amounts recommended in Official Disability Guidelines. In this case there is a clear exception there are clear exceptional factors the patient's range of motion weakness range of motion and strength assessments of the right shoulder noted on the most recent physical therapy records. The patient continued to have a significant amount of range of motion loss and mild to moderate weakness on physical examination. The patient had met had been progressing toward both short and long

term goals and was compliant with physical therapy recommendations. Given the obvious exceptional factors in this case to include multiple surgical procedures and persistent loss of range of motion as well as weakness after 23 sessions physical therapy, it is this reviewer's opinion that medical necessity for continued physical therapy 3 x a week x 4 weeks is established and the prior denials are overturned.

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

ACOEM-AMERICA 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 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 (PROVIDE A DESCRIPTION)