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An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 01/15/2016

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:

12 additional physical therapy visits for 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)

This patient is a male who was post right shoulder arthroscopic subacromial and subcoracoid decompression, biceps tenotomy, and repair of the subscapularis, performed on XX/XX/XX. Postoperatively, the patient had completed at least 30 physical therapy sessions. Per a progress evaluation, the patient had progressed slightly and was able to carry 10 pound objects using the affected hand with severe difficulty. Initial evaluation findings noted right PROM of 57 degrees on flexion, 30 degrees on extension, 45 degrees on abduction, and 0 degrees of adduction. There was only trace strength noted at the time. Evaluation findings revealed active range of motion of 37 degrees, extension of 53 degrees, abduction of 51 degrees and adduction, internal and external rotation of 0 degrees with poor strength in all motions, with the exception of extension which had fair strength. The most recent evaluation notes the patient to be 4 months postop. Per the note, the patient has been trying to work on range of motion and strengthening on his own and felt that he was slowly improving. He rated his pain at a 2/10 and noted that he was able to sleep, but still had weakness with abduction or external rotation. On examination, he had muscle strength measuring at 4/5 with subscapularis lift off, 3/5 in abduction and 5/5 in internal and external rotation. He had full passive range of motion of the right shoulder and all provocative testing was negative. The plan was for the patient to continue with physical therapy. This request is regarding the medical necessity of 12 additional physical therapy visits for the right shoulder.

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

Per the Official Disability Guidelines recommendations, physical therapy for the patient's condition is supported at 24 visits over 14 weeks. It is also stated that treatment frequency should be faded and an active self directed home physical therapy program should be implemented as a continuation of therapy. The patient has already exceeded the allotted number of sessions warranted for his condition, and he is well beyond the recommended 14 week postoperative treatment period. He has full passive range of motion per the most recent note, and decreased strength in only abduction and subscapularis lift off. The patient should

be well versed in a self directed home exercise program for a continuation of his therapy to address his remaining deficits. There are no exceptional factors noted to support exceeding the above noted guidelines with an additional 12 sessions of physical therapy. Given the above, this request is not supported. As such, the request is not 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)