True Decisions Inc.

An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy XX-XX X week X X weeks for the XX

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

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☒ Partially Overturned	Agree in part/Disagree in part
☐ Upheld	Agree

Six additional sessions are medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. The mechanism of injury was not available in the medical records. XXXX was diagnosed with XX syndrome of the XX XX, bicipital XX of the XX XX and XX XX XX lesion of the XX XX. XXXX underwent surgery on XXXX for XX XX (SAD), biceps XX, and XX XX XX from XX to XX (XX) XX. Per therapy orders dated XXXX, the plan was to continue ongoing treatment including physical therapy evaluation and treatment XX to XX times a week for XX weeks. XXXX completed a physical therapy re-evaluation on XXXX for XX XX pain. XXXX reported XX-XX% relief but could not lift anything above XXXX head. The pain was rated at XX/10 at rest and XX/10 with activity. The exacerbating factors included movement of the affected XX, and relieving factors were medications and ice application to the affected area. On examination, XXXX had XX to palpation over the XX XX XX, XX, and XX muscles. If XXXX XX XXXX XX XX too long, it started to XX. XX of the arm, shoulder, and hand (XX) score was XX.7. XXXX XX passive external rotation with the arm at XX degrees abduction, was painful and limited to XX degrees. XXXX hiked XXXX XX XX quite a bit as XXXX went past XX degrees of flexion / XX. XXXX was weak in XXXX XX arm from the injury. XXXX was making slow but steady progress with strength and range of motion. It was recommended that

XXXX progress as XXXX was able. On XXXX, XXXX evaluated XXXX for a follow-up. XXXX was XX months status post XX biceps XX, XX XX, and XX of the XX. XXXX continued to have some pain and weakness in the XX shoulder. XXXX stated XXXX did not seem to be improving much. Examination showed forward elevation passively XX degrees, external rotation XX degrees, and abduction XX degrees. Actively; XXXX could raise the arm to XX degrees forward elevation with XX degrees external rotation, and behind the back reaching to the level of XX. XXXX had weakness of the XX and XX at XX to XX+/5. XXXX continued to have a painful Speed's test. XXXX had XX with passive range of motion of the shoulder. XXXX ongoing work duty status would be XX pounds lifting, pushing, and pulling with nothing above the shoulder. The treatment to date included medications (XXXX); XX XX tendon XX, XX decompression, and XX of XX on XXXX; XX sessions of physical therapy with improvement, sling, XX injection in the XX sheath with relief for a XX, and home exercise program. Per a utilization review determination letter dated XXXX, the request for physical therapy XX to XX times per week for XX weeks for the XX shoulder (XX physical therapy sessions) was denied. Rationale: "In this case, the XXXX patient sustained an injury on XXXX. The patient was diagnosed with XX syndrome of the XX shoulder, bicipital XX, XX XX and superior XX XX XX of the XX XX. There was no subjective complaints and objective findings documented in the medical report submitted with this request. ODG XX (updated 9/10/2018) – Physical therapy recommended. Postsurgical treatment, arthroscopic: XX visits over XX weeks." Based on the records provided, the patient completed XX sessions of therapy post biceps XX and ODG criterion recommends up to XX sessions of physical therapy postop. The medical records provided did not document physical examination findings supporting the need to deviate from ODG recommendations and there was no medical rationale offered support for the need to deviate from guideline recommendations. Also, this is a Texas case that cannot be modified. Therefore, the requested physical therapy XX to XX times a week for XX weeks for the XX XX is not medically necessary." Per a reconsideration review determination letter dated XXXX by XXXX, the appeal request for physical therapy XX to XX times per week for XX weeks for the XX shoulder (XX physical therapy sessions) was not approved. Rationale: "As per ODG XX (updated 9/10/2018), "XX XX XX/XX syndrome: Medical treatment: XX visits XX XX weeks Post-injection treatment: XX visits over XX-week Post-surgical treatment, arthroscopic: XX visits over XX weeks Post-surgical treatment, open: XX visits over XX weeks" XXXX. The patient notes pain and some weakness in the XX. Actively, the patient could raise the arm to XX degrees forward elevation with XX external rotation, and behind the XX reaching to the level of XX. There was weakness of the XX and XX, at XX to XX. The patient continued to have a painful XX test. There was XX with passive range of motion of the XX. The patient underwent XX XX XX XX, XX decompression, and XX of XX on XXXX. The patient has completed XX sessions of therapy post XX XX. Therefore, continued therapy is indicated; however, at a modified number of XX in support of demonstration of continued improvement and/or decrease in pain and transition into a prescribed independent home exercise program. However, due to TX Law and no agreement being reached, this request is not medically reasonable and necessary, at this time. As such, the requested appeal physical therapy XX-XX times a week times XX weeks XX XX is upheld."

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

The ODG supports the utilization of physical therapy following surgical intervention the shoulder. The guidelines recommend up to maximum XX sessions following the completed surgical procedure. The documentation available indicates that at least XX sessions were attended with improvement, but persistent deficits. Both utilization review as indicated that an agreement regarding modification the request could not be achieved and as such, the entire request had to be denied. The documentation did not indicate exceptional factors that would warrant XX additional therapy sessions were total of XX sessions. Partial certification for XX additional sessions would be recommended. This would represent partial upholding the prior denial as the prior reviewers have recommended partial certification of XX sessions, but agreement cannot be obtained and as such, modification cannot be completed by the prior reviewers.

Given the documentation available, XX additional sessions of PT would be considered medically necessary and the decision is partially overturned.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
☐ MILLIMAN CARE GUIDELINES
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
☐ TEXAS TACADA GUIDELINES
☐ TMF SCREENING CRITERIA MANUAL