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DATE: 7/18/18

IRO CASE #: XXXX
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Physical Therapy 2-3 Times Per Week for 6-8 Weeks- Right Shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is specializes in Physical Medicine and Rehabilitation with over 25 years of experience.
REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
Claimant is a XX with a work related injury to XX R shoulder on XX while walking down XX and tripped. XX reached out with XX R shoulder to catch XX chair and it rolled out on XX. Had a work related fall at home roughly XX.

XX: Physical Therapy Note. Right shoulder pain of 8/10. Examination- AROM: Flexion is 70degrees, abduction of 52 degrees, internal rotation at L2 and external rotation of 34 degrees. Manual muscle testing on flexion and abduction is 4/5 and adduction and internal and external rotation is 5/5. Biceps loading test, Hawkins's Kennedy test, Neer's test, painful are sign, and compression is positive.

XX: MRI Right Shoulder. Impression- Slap Tear. No high-grade partial or full-thickness cuff tears identified. Moderate primary osteoarthritic change AC joint.

XX: Office Visit. Increase in symptoms. Right shoulder pain. Pain is 4/10, constant ache. Diagnosis- 1. R shoulder pain/stiffness. 2. R frozen shoulder/adhesive capsulitis. 3. R SLAP tear. 4. R SIS. 5. R ACJ ds. Since XX XX year, pt states increasing pain in XX rt shoulder that is worse with any activity and improved with immobility and rest. XX has not had any relief of discomfort with non-operative management, including PT and oral medication. XX pain is constant and is limiting XX ability to perform daily activity. XX also has a decrease in ROM to the shoulder. Denies paresthesias or pain radiation. XX Impression- R shoulder pain secondary to R SLAP tear and frozen shoulder. Since XX has not underwent formal therapy for almost a year, Rx was given to attempt to improve ROM. Rx also given for dynamic splint, XX XX gel to help with discomfort. We feel this medically necessary at this time. Light duty if available.

XX: PT XX. Pt is unable to reach over XX head, lift objects, and perform most ADL's secondary to pain. XX reports limitations with regards to self-care tasks and driving. XX would benefit from skilled PT to address above issues. Severe guarding/apprehension with all movement, including passive ROM. Additional testing not performed due to pain and confirmed SLAP tear. Pt demonstrates decreased strength, decreased ROM and

shoulder pain. Examination- AROM on flexion of 79 degrees and passive of 64, abduction of 53 degrees and passive of 51, passive internal rotation of 42 degrees, and active and passive external rotation of 6 degrees. Manual testing 2+.

XX: UR by XX. Rationale- Per Pre-Auth form dated XX, the patient had 6 approved PT visits. Prior treatments include PT. Per guidelines, the recommended number of PT visits for sprained shoulder; rotator cuff tear is 10 visits over 8 weeks. The pt was approved for 6 PT visit. XX was recommended PT of 2-3 x's per week for 6-8 weeks. However, the current request in addition to the previously completed and/or approved sessions exceeds guideline recommendation. There was limited documentation of significant clinical changes to validate the efficacy of prior sessions rendered. There were no exceptional factors to support ongoing supervised therapy versus maintenance home exercise. Non-certified

XX: Internal Communication. Pt continues to experience significant shoulder pain with limitations in strength and ROM. These limitations have significantly limited XX functional ability. Pt is unable to reach over XX head, lift objects, and perform most ADL's secondary to pain. XX reports limitations with regards to self-care tasks and driving. XX would benefit from skilled PT to address above issues.

XX: Office Visit with XX. Mod-sev pain. 4-6/10, almost constant, exacerbated by overhead usage, away from body, or reaching. Interfering with ADL's and work duties. Relates pain radiation to neck/shoulder blade o/w no distal neuro symptoms. XX R shoulder has somewhat improved w/rest and activity modification. W/C hasn't approved PT, Estim, splinting or medications. Still very limited regarding pain/lack of motion R shoulder. Examination- R shoulder. ATE=PTE 100deg w/pain past 75; +impingement signs; TTP over ACJ; + X-body adduction test; painful Speed's; 4/5 drop arm; IR to waist and ER to cheek w/discomfort at extremities. RT shoulder x-ray shoe no acute bony abnormalities; MR images show no signal changes in labrum c/w SLAP tear. Plan: Recommend aggressive formal PT rehab per protocol. Reorder XX gel and dynamic splint; also ESTIM device; all are medically necessary to help with function and symptoms. Light duty if available at work. Avoid proactive maneuvers at this time. RTC 1-2 months for repeat eval and further management recommendations.

XX: UR by XX. Rationale- The proposed plan is not consistent with our clinical review criteria. The current request already exceeds the guideline recommendation, specifically the request amounts 24 PT visits. Given the XX of injury, clarification is needed regarding the total completed PT sessions to date. There are no exceptional factors to support ongoing supervised therapy versus maintenance home exercise. I did make multipole attempts to contact the provider for additional information or clarification. However, based on the current documentation, the request is not supported.

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

The previous adverse decisions are Upheld. The request exceeds ODG recommended number and time frame for basic PT for submitted diagnoses, and clinically there is notation of previous Physical Therapy with no documentation of results in shoulder range of motion and strength with that Physical Therapy. There is also no documentation of instruction in and compliance with a home exercise program. There is also no clinical information regarding intervening work up and treatment, intervening injury, and return to function now one full year since the original date of injury. Therefore, request for Physical Therapy visits 2-3 times a week for 6 to 8 weeks is considered not medically necessary.

PER ODG…..XX

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**

- ☐ **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)**