Applied Independent Review

An Independent Review Organization

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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:
PT 3 X 4 total 12 visits for the shoulders and upper back area

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 case involves a XXXX with history of an occupational claim from XXXX. The patient was XXXX, resulting in a shoulder injury. XXXX was diagnosed with superior labral anteroposterior lesion and arthrosis of the right shoulder. According to submitted documentation, the patient previously underwent 24 sessions of physical therapy in XXXX. There were multiple shoulder surgeries, including SLAP repair on XXXX, manipulation under anesthesia with synovectomy on XXXX, and distal clavicle excision on XXXX. The patient had previously been recommended for additional physical therapy, although this request was denied due to unclear response from prior physical therapy, and no indications of any exceptional factors to support exceeding guideline recommendations for treatment. On XXXX, the patient presented for follow-up with right shoulder pain. The provider noted that the patient continued to have shoulder discomfort and limitation, with some weakness issues. XXXX was progressing with day-to-day activities. On physical examination, there was full passive range of motion at the shoulder, with slight swelling at the trapezius. Cervical spine range of motion was within normal limits, with pain. Rotator cuff strength was maintained, and O'Brien's test was negative. The treatment plan included recommendation to proceed with physical therapy.

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

Regarding the request for 12 visits of physical therapy for the shoulders and upper back, the available documentation indicated that additional therapy had been previously denied as the patient had already completed 24 visits of therapy in XXXX. There is no description of a reinjure or exceptional factors noted to support extending treatment beyond guideline recommendations for treatment. There were no additional findings supported following the initial denials that would support overturning the prior decision. As such, PT 3 x 4, 12 total visits for the shoulders and upper back area remain non-certified, and the prior denial is upheld.

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 AHRQ-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)