

Clear Resolutions Inc.

An Independent Review Organization

6800 W. Gate Blvd., #132-323

Austin, TX 78745

Phone: (512) 879-6370

Fax: (512) 572-0836

Email: resolutions.manager@cri-iro.com

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Description of the service or services in dispute:

Additional six sessions of physical therapy for the right shoulder.

Description of the qualifications for each physician or other health care provider who reviewed the decision:

Board Certified Orthopedic Surgeon

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

- Overturned (Disagree)
- Upheld (Agree)
- Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX who sustained an industrial injury on XXXX. XXXX was diagnosed with injury of unspecified body region.

An addendum to the peer review report dated XXXX included an office note, which was completed on XXXX. The examination showed tenderness to palpation of the glenohumeral region, limited active range of motion of the right shoulder (abduction 72 degrees in neutral, abduction 52 and 90 degrees, flexion 170 degrees, internal rotation 70 degrees at 90 degree abduction and abduction at 130 degrees) and 4/5 muscle strength for abduction. XXXX continued to show improvement, but had not yet met the maximum medical improvement and was requesting six additional sessions of physical therapy two times a week for three weeks.

An MR arthrogram in XXXX showed full thickness tear of the supraspinatus tendon extending for 12 mm in the anteroposterior dimension with 10 mm of retraction; posterior labral tear; and moderate thickening coracoacromial ligament narrowing the acromiohumeral space to 5 mm.

The treatment to date included physical therapy (42 sessions), home exercise program, transcutaneous electrical nerve stimulation (TENS), XXXX injection, right shoulder arthroscopic rotator cuff repair of full thickness tear with protraction, superior labrum anterior and posterior (SLAP) repair, bursectomy and subacromial decompression.

Per an adverse determination letter dated XXXX, the clinical findings did not appear to support the medical necessity of treatment of additional six sessions of physical therapy for the right shoulder. Per a Peer Clinical Review Report dated XXXX, the request for additional six sessions of physical therapy for the right shoulder was not certified. The rationale was: "During the peer-to-peer discussion, XXXX said that this was requested because the patient "is not there yet," but is showing improvement and is still lacking range of motion, mostly abduction. The patient is almost 6 months post-surgery and has completed approximately 42 postop physical therapy sessions. Additional visits would exceed guideline recommendations for the patient's condition. The patient should be well versed in a home exercise

program at this point for further gains, Therefore, my recommendation is to non-certify the request for additional physical therapy 6 sessions (right shoulder).”

Per an addendum to the peer review report dated XXXX, an appeal for additional physical therapy 6 sessions (right shoulder) was non-certified. The Principal Reason(s) for Determination was: “Based on the clinical information provided, the appeal request for additional physical therapy 6 sessions (right shoulder) is not recommended as medically necessary. A recent request for physical therapy for the right shoulder was non-certified noting that the patient is almost 6 months post-surgery and has completed approximately 42 postop physical therapy sessions. Additional visits would exceed guideline recommendations for the patient's condition. The patient should be well versed in a home exercise program at this point for further gains. There is insufficient information to support a change in determination, and the previous non-certification is upheld. In this case, patient is now almost 6 months post-surgery and has attended approximately 42 postop physical therapy sessions. Additional skilled treatment exceeds Official Disability Guidelines (ODG) in terms of duration of treatment as well as number of sessions. There is no clinical evidence to suggest that additional skilled physical therapy will be any more beneficial than performance of home exercise program. The patient should be well-versed in an independent exercise program by now considering the amount of therapy that has been completed and should address any remaining objective functional deficits. It is reasonable to consider that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Therefore, medical necessity is not established in accordance with current evidence based guidelines.”

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

The ODG recommends up to 30 visits of physical therapy following rotator cuff repair. The provided documentation indicates a history of a right shoulder rotator cuff repair, superior labrum repair, and subacromial bursectomy on XXXX with a completion of 42 visits of postoperative physical therapy with continued improvement in range of motion and strength, and there is no indication of why transition to a home exercise program cannot be completed following 42 supervised visits of physical therapy. The injured worker should be well-versed in an independent home exercise program following 42 visits of supervised physical therapy. Based on the provided documentation, recommendation is that the two previous determinations for noncertification of six additional physical therapy visits be upheld. Given the documentation available, the requested service 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
- 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

Physical therapy- Recommended. Positive (limited evidence). See also specific physical therapy modalities by name.

See the Low Back Chapter for more information. See also more specific listings: Activity restrictions; Acupuncture; Bipolar interferential electrotherapy; Biofeedback; Biopsychosocial rehab; Cold lasers; Cold packs; Continuous-flow cryotherapy; Continuous passive motion (CPM); Cutaneous laser treatment; Deep friction massage; Diathermy; Dynasplint system; Electrical stimulation; Ergonomic interventions; ERMI Flexionater®/ Extensionater®; Exercises; Flexionators (extensionators); Game Ready™ accelerated recovery system; Graston instrument assisted technique (manual therapy); Home exercise kits; Ice packs; Interferential current stimulation (ICS); Iontophoresis; Kinesio tape (KT); Low level laser therapy (LLLT); Manipulation; Massage; Mechanical traction; Neuromuscular electrical stimulation (NMES devices); Occupational therapy; Polar care (cold therapy unit); Range of motion; Return to work; Static progressive stretch (SPS) therapy; TENS (transcutaneous electrical nerve stimulation); Thermotherapy; Ultrasound, therapeutic; Work; Work conditioning, work hardening.

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also, see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Rotator cuff syndrome/Impingement syndrome:

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

Sprained shoulder; rotator cuff tear:

Medical treatment, sprain: 10 visits over 8 weeks

Medical treatment, tear : 20 visits over 10 weeks

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

Massive rupture of rotator cuff:

Post-surgical treatment, arthroscopic: 30 visits over 18 weeks

Post-surgical treatment, open: 40 visits over 18 weeks

Adhesive capsulitis:

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

Dislocation of shoulder:

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

Acromioclavicular joint dislocation:

AC separation, type III+: 8 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

Superior glenoid labrum lesion:

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks

Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified):

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

Brachial plexus lesions (Thoracic outlet syndrome):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Fracture of clavicle:

8 visits over 10 weeks

Fracture of scapula:

8 visits over 10 weeks

Fracture of humerus:

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

- 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 Medical Literature (Provide a description)
- Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.