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IRO Certificate #XX

DATE OF REVIEW: 3/02/18
IRO CASE NO. XXXX
DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Physical Therapy, Right Shoulder, 97110, 97140, 97014 (12 units ea)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified in Pain Management & Rehabilitation

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

Upheld **(Agree)** **X**

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

PATIENT CLINICAL HISTORY SUMMARY

The patient was injured in a work related injury in XXXX. It was a XXXX. Ultimately, after failing a short course of conservative care, the patient underwent a right shoulder rotator cuff repair on XXXX. XXXX subsequently went on to have continued post operative care utilizing analgesics and 38 sessions of physical therapy. XXXX had in place long term goals of decreasing pain, increasing range of motion, increasing strength and, ultimately, becoming independent with a written home exercise program at the 4 week mark. An initial physical therapy re-examination dated XXXX showed the patient to have on the right side shoulder passive range of motion, flexion 90 degrees, abduction 90 degrees, external rotation in scapular plane 30 degrees, and internal rotation in scapular plane 30 degrees. Patient's gross motor testing on the right shoulder flexion, shoulder abduction, shoulder internal rotation, external rotation, and shoulder scaption were all graded 2+/5 on XXXX.

After reviewing XXXX sessions of physical therapy, a note dated XXXX revealed the patient to have achieved improvement in almost all of XXXX parameters tested particularly looking at shoulder active range of motion flexion 150 degrees, abduction 140 degrees, functional external rotation reach was C4 and internal rotation reach was sacrum. In regards to motor strength testing shoulder flexion was 3+, shoulder abduction was 3/5, shoulder internal rotation 3+, shoulder external rotation 3+, and shoulder scaption 3/5.

At this time the physical therapist reports patient making steady progress in mobility and right shoulder upper extremity. Patient to benefit from continued skilled care to assist with improving functional mobility and return to PLF in a safe and timely manner.

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

Opinion: I agree with the benefit company's decision to deny the requested service.

Rationale: The rationale for my opinion is that the patient, after 38 sessions of physical therapy, only increased XXXX strength grade by 1 grade: 2+/5 to 3+/5. This does not demonstrate a significant increase or expected outcome. XXXX had exceeded the recommended treatments per ODG by 14 visits. There is not a strong indication or any extenuating factors here that would suggest that XXXX would make dramatic gains with the same treatment management. XXXX has achieved significant improvements in mobility. I do think that the prescribed independent home exercise program with therapy and even traditional strength training at home is reasonable to allow XXXX to return to XXXX prior level of functionality in a safe and timely manner.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGE BASE
AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS X
MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
MILLIMAN CARE GUIDELINES
ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X
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 DESCRIPTION)
OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE DESCRIPTION)