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Date notice sent to all parties: 03/06/18

IRO CASE #: XXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy for the right shoulder 3 times a week for 4 weeks

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME:

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

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

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

Physical therapy for the right shoulder 3 times a week for 4 weeks – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant presented to the emergency room on XXXX noting XXXX, injuring XXXX left pretibial area, left elbow, and scrapes to the arms. XXXX had no LOC or neck or back pain. XXXX had an abrasion of 4 cm that was non-draining at that time with some slight redness. There were several small scratches to both arms. XXXX was ambulating in the room and they attempted to discharge XXXX and XXXX became pale, diaphoretic, and stated XXXX ears were ringing. XXXX was not discharged at that time. XXXX was then discharged at a later time that day. XXXX examined the claimant on XXXX for XXXX right shoulder, neck, upper back, left lower leg, and lower back. The impressions were abrasion of left lower leg, cervical strain, arm contusions, lumbar contusion, lumbar strain, right shoulder strain, sprain of ligament of left ankle, XXXX, and strain of right pectoralis muscle. An MRI of the right shoulder was obtained on XXXX and revealed 15% thickness undersurface and

intrasubstance partial tearing of the supraspinatus tendon and 10% thickness undersurface and intrasubstance partial tearing of the infraspinatus tendon. A small glenohumeral joint effusion and small subacromial/subdeltoid bursitis was also noted, as well as AC joint capsular hypertrophy and lateral acromion downsloping. On XXXX, XXXX noted the claimant had been going to therapy and was generally not improving or functioning as well. Another MRI was recommended with contrast to further evaluate the shoulder. The MRI arthrogram was then obtained on XXXX and revealed mild distal supraspinatus and infraspinatus tendinosis with minimal articular surface tearing of the anterior supraspinatus and posterior infraspinatus tendons at their insertions. A non-displaced SLAP type II tear of the labrum was suspected. There was also suggestion of a non-displaced tear of the anterior labrum at the chondral-labral junction. The tears are superimposed on mild degeneration. Mild AC osteoarthritis was noted, as well as moderate subacromial and subdeltoid bursal fluid/bursitis. An EMG/NCV study on XXXX revealed a normal electrodiagnostic study. The claimant was then initially evaluated in therapy on XXXX. XXXX had a steroid shot in the right shoulder a week prior that helped for 2 days. Therapy was recommended for a total of 18 visits, as XXXX had already had therapy with minimal improvement. XXXX attended therapy on XXXX and was then reevaluated on XXXX. XXXX then continued in therapy on XXXX, XXXX, XXXX, XXXX, XXXX. XXXX. XXXX, and XXXX. XXXX was then evaluated on XXXX and then attended more therapy on XXXX, XXXX, and XXXX. XXXX was then discharged on XXXX. XXXX strength and range of motion in the right shoulder had improved. XXXX was discharged with good knowledge of XXXX home exercises and a lack of significant improvement. XXXX then began seeing the patient on XXXX who performed a right shoulder steroid injection. XXXX then performed right shoulder arthroscopy, tenodesis of the long head of the biceps tendon, acromioplasty, adhesiolysis of the glenohumeral joint, and extensive bursectomy of the labrum, capsule, supraspinatus, and bursa on XXXX. XXXX was then reevaluated in therapy on XXXX for XXXX postoperative therapy, which was requested 2 times a week for 6 weeks. XXXX then attended therapy from XXXX through XXXX, at which time XXXX was reevaluated. On XXXX, XXXX recommended more therapy due to pain and stiffness. Eighteen additional sessions would be recommended. The claimant then continued in therapy from XXXX through XXXX. XXXX was then reevaluated in therapy on XXXX. Strength and range of motion were slightly improved and therapy was recommended 3 times a week for 5 weeks. XXXX then continued in therapy from XXXX through XXXX. XXXX was then reevaluated on XXXX. XXXX was XX only at that time. XXXX was still currently making progress and could get XXXX arm behind XXXX back a little better. Additional therapy for a total of 12 visits was recommended at that time. On XXXX, XXXX examined the claimant on XXXX and XXXX denied any pain at that time. XXXX no longer needed pain medications. XXXX had improved range of motion and was still in therapy 3 times a week. Right shoulder abduction lacked 5 degrees versus 40 degrees in the left shoulder, which signified significant posterior capsule tightness. It was felt the claimant required 18 more sessions of therapy. On XXXX, a denial of the requested therapy was provided. The claimant continued in therapy on XXXX and XXXX. On XXXX, a request for additional therapy was made, as the claimant could not reach behind XXXX back still. On XXXX another denial was provided for the requested physical therapy. On XXXX, the claimant attended therapy. XXXX rated XXXX pain at 1/10 and still had some tightness/fleeting soreness in XXXX right shoulder, but felt XXXX was making slow/steady progress. It was noted XXXX was awaiting more approval for therapy at that time. On XXXX, another denial was provided for the requested physical therapy. On XXXX, XXXX provided a letter "To Whom It May Concern". XXXX noted XXXX had attended therapy and XXXX range of motion had improved drastically; however, XXXX was being denied continued therapy despite doctor orders. XXXX was noted to be an XXXX and it was felt XXXX would need more therapy to condition XXXX to lift heavy weight overhead so XXXX could do XXXX job safely.

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

Based on the documentation provided, the claimant underwent arthroscopic right shoulder surgery on XXXX. XXXX has received over 30 sessions of therapy postoperatively in XXXX and 14 additional sessions, including reevaluations in XXXX. The claimant has shown functional improvement and has made significant strides towards XXXX goals, meeting many of them. At this time, XXXX should be independent in a home exercise program. Based on the criteria of the Official Disability Guidelines (ODG), for post arthroscopic treatment, 30 visits over 18 weeks is appropriate. The claimant has exceeded this number of sessions as recommended by the ODG. There is no indication that further formal physical therapy will assist XXXX or provide additional significant functional improvement or benefit. Therefore, the requested physical therapy for the right shoulder 3 times a week for 4 weeks is neither reasonable nor necessary, as it is not in accordance with the ODG. The previous adverse determinations should be upheld at this time.

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**
- ☐ **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**
- X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- X **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)**