US Decisions Inc.
An Independent Review Organization
8760 A Research Blvd #512
Austin, TX 78758
Phone: (512) 782-4560
Fax: (512) 870-8452
Email: manager@us-decisions.com

May 22, 2018

Description of the service or services in dispute:

Outpatient physical therapy treatment
97110 - Therapeutic exercises and treatment for strength and movement recovery
97140 - Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist
97164 - Physical Therapy Reevaluation established plan care

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

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 is a XXXX who was diagnosed with strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm, subsequent encounter (S46.911D); and strain of muscle, fascia and tendon of the right hip, subsequent encounter (S76.911D). On XXXX, XXXX and reported pain in the right hip. XXXX had continued hip pain with pain in the right piriformis as well as decreased range of motion and functional limitations.

A physical therapy progress report documented that XXXX presented to XXXX on XXXX for right shoulder complaints. XXXX reported the pain had decreased to 2/10. On examination, right shoulder active range of motion was within normal limits. XXXX continued to have decreased strength in the right shoulder and weakness of rotator cuff with +3/5 empty can test. Disabilities of the Arm, Shoulder and Hand (DASH) score was 54 indicating 20% to 39% impairment.

Treatment to date included physical therapy (17 sessions) with modalities to include manual therapy and therapeutic exercises.

Per a utilization review initial adverse determination letter dated XXXX by XXXX (Physical Medicine and Rehabilitation), the request for continued physical therapy two times a week for three weeks was denied. The rationale for determination was as follows: "Since the request exceeds ODG guidelines of 10 visits for a shoulder sprain, I cannot recommend approval without peer discussion."

A utilization review reconsideration adverse determination letter by XXXX (XX) dated XXXX documented that the reconsideration request for continued physical therapy two times a week for three

weeks was not certified as medically necessary. The rationale for denial was as follows: "The initial request was non-certified noting that since the request exceeds ODG guidelines of 10 visits for a shoulder sprain, I cannot recommend approval without peer discussion. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient has completed at least 17 physical therapy visits to date. Current evidence-based guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and / or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The most recent progress report submitted for review is over 3 months old. 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.

Given the current clinical data, the request for continued physical therapy 2 x a week x 3 weeks 97110 97140 97164 is not recommended as medically necessary. The initial request was non-certified noting that the request exceeds ODG Guidelines of 10 visits for a shoulder sprain. The denial was upheld on appeal noting that the patient has completed at least 17 physical therapy visits to date. Current evidence-based guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. When treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. There are no exceptional factors of delayed recovery documented. The most recent progress report submitted for review is over 3 months old. There was no additional clinical data provided to address the issues raised by the previous denials. The number of physical therapy visits completed to date has already exceed guideline recommendations with no exceptional factors documented. There are no barriers documented which would preclude the patient from performing a home exercise program. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Given the documentation available, the requested service(s) is considered 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 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

  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

- ☐ 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)