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:

Physical therapy XX times a week for four weeks for the XX XX.
XX: Therapeutic procedure, 1 or more areas, each 15 minutes
XX: Therapeutic activities that involve working directly with the provider
XX: Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist
XX: Group therapeutic procedures
XX: Application of hot or cold packs, each 15 minutes
XX: Re-learning neuromuscular movement
XX: Ultrasound, each 15 minutes
XX: Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care.

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 was diagnosed with XX XX XX XX of the XX XX, initial encounter. (XX XX: XX.XX). XXXX.

On XXXX was evaluated by XXXX for XX XX pain. There was a painful range of motion and XX and XX sensation with XX of the XX. XXXX was working XX duty. The examination showed tenderness on the XX XX XX XX XX. XX muscle was painful. The XX range of motion on active forward XX was XX degrees and passive forward XX was XX degrees. Internal active rotation was up to XX XX and the passive external XX was XX degrees. XX XX test was XX on the XX. XX XX test was XX. An MRI of the XX dated XXXX was reviewed, which showed XX XX XX and XX (XX) and XX XX XX, XX XX. X-rays of the XX dated XXXX was unremarkable.

Per a utilization review determination letter dated XXXX, the request for XX physical therapy sessions, XX times a week for XX weeks for the XX XX as an outpatient, status post subsequent XX / XX XX XX between XXXX was non-certified. The examination revealed decreased pain levels at rest, sleeping better, and less sharp pain with active movement. XXXX reported limited active movement, passive range of motion remaining significantly limited, and high pain levels at the XX XX with external rotation, which was limited to XX-XX degrees. XXXX impairments included range of motion, muscle strength, pain and impaired flexibility. XXXX functional limitations included limitations in XXXX management, performing some sports activities and performance and work activities. However, XXXX was noted to have XX previous physical therapy visits. Additionally, the submitted documentation did not indicate as to why XXXX could not participate in a home exercise program following the previously-authorized physical therapy visit. Therefore, the request for physical therapy XX times a week for XX weeks for the XX XX, as an outpatient status post subsequent XX/XX XX repair on XXXX was not medically necessary.

A letter dated XXXX indicated that the reconsideration request was denied/non-certified. Rationale: "Understanding the date of injury, during the surgery completed, given the amount of physical therapy already performed, and there is no specific objective clinical assessment by the treating surgeon demonstrating any efficacy or utility with the physical therapy completed, there is insufficient objective clinical data presented supporting additional protocol be pursued. Furthermore, after speaking with XXXX stated the patient had XX-XX sessions after surgery. The patient's range of motion is XX, and they are still having pain. After this discussion, there is a discrepancy on how much therapy has been done postoperatively. The patient has not been recently evaluated, and it appears this request has been delayed by XX XX; however, as it is unclear the amount of therapy, and the patient's current status, the request is not medically necessary."

Treatment to date consisted of medications, surgical intervention (XX XX XX in XXXX and XX XX XX, XX XX XX / XX repair on XXXX), XX-XX, home exercise program (stated pain with table slides) and physical therapy (without relief).

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

Based on the clinical information provided, the request for Physical therapy XX times a week for XX weeks for the XX XX XX: Therapeutic procedure, 1 or more areas, each 15 minutes, XX: Therapeutic activities that involve working directly with the provider, XX: Manual therapy techniques, each 15 minutes, requiring direct contact with physician or therapist, XX: Group therapeutic procedures, XX: Application of hot or cold packs, each 15 minutes, XX: Re-learning neuromuscular movement XX: Ultrasound, each 15 minutes, XX: Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care is not recommended as medically necessary and the previous denials are upheld. The patient has completed at least XX postoperative physical therapy visits to date. Current evidence based guidelines support up to XX 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. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

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
  Shoulder Chapter/Physical Medicine
  Superior glenoid labrum lesion:
  Medical treatment: 10 visits over 8 weeks
  Post-surgical treatment (labral repair/SLAP lesion): 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.