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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Continued Physical Therapy 2-3 X week X 5 weeks

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

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a XXXX with a history of an XX claim from XXXX. XXXX. The patient was diagnosed with XX rotator cuff, and XX joint degeneration. Prior treatment included medications, activity modifications, a home exercise program, XX shoulder rotator cuff repair, and physical therapy. The patient was seen on XXXX with ongoing pain in the shoulder, as well as weakness. XXXX had prior XXXX injections and completed a home exercise program, with little to no improvement. XXXX pain level was rated 8/10. The provider noted that previous treatments such as activity modification, thermal modalities, external mobilization, medications, therapy, injections, and surgery has been helpful. Examination revealed decreased range of motion with decreased strength. The request was previously submitted for continued physical therapy XX-XX times per week for XX weeks. This request was initially denied due to exceeding evidence-based guidelines. A letter from the provider dated XXXX indicated that the patient had a history of XX shoulder surgery and was status post XX shoulder replacement and XX transfer. XXXX pain had been severe and bothersome. XXXX underwent a XX block and radiofrequency ablation of the XX XX nerve which helped by 50%. XXXX had been participating in physical therapy which improved functionality and quality of life, although XXXX pain returned since stopping therapy. On examination, there was 45° of abduction, and limited internal rotation. There were spasms noted. The recognition was made for additional physical therapy to improve motion of the left shoulder, as well as to allow the patient to develop a home exercise program. The request was again denied, as there was insufficient information to support a change in determination as the patient had undergone extensive physical therapy today without documentation of significant and

sustained improvement.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The Official Disability Guidelines allow up to XX-XX visits of therapy for patients who have undergone rotator cuff procedures, with a focus on tapering to a home exercise program. In this case, the request for additional therapy had been denied multiple times due to exceeding guidelines. The provider indicated that the patient had ongoing deficits and radiating pain in the shoulder to be addressed by additional therapy sessions. However, there was still no documentation of any contraindications to participation in a home exercise program, as the patient should have been adequately instructed in home exercise at this point in treatment. Further therapeutic visits continue to exceed guidelines, and there were no exceptional factors noted to support the request. Therefore, continued physical therapy XX-XX times per week ×XX weeks is not medically necessary and therefore upheld.

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
☐ AHRQ- 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
☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
☐ MILLIMAN CARE GUIDELINES
☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)
☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR
☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
☐ TEXAS TACADA GUIDELINES
☐ TMF SCREENING CRITERIA MANUAL

Official Disability Guidelines (ODG), Treatment Index, 16th Edition (web), 2018, Shoulder, Physical Therapy.