Applied Resolutions LLC

Notice of Independent Review Decision

Case Number: XX Date of Notice: 1/25/2019 9:28:03 AM CST

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IRO REVIEWER REPORT

Date: 1/25/2019 9:28:03 AM CST

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Additional physical therapy X XX sessions for the XX XX

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]: XX. XX XX is a XX-year-old XX who was diagnosed with a XX XX XX XX XX and XX (XX) tear and XX XX XX damage and XX initial encounter. (XX.XX). XX sustained a XX XX injury on XX while XX was XX and was XX. XX XX while XX maintained XX XX and consequently XX XX through XX XX XX. XX. XX had a postoperative evaluation by XX on XX. XX was XX weeks status-post XX XX XX XX XX and XX XX repair, complicated by adhesive XX on XX. XX was doing well and was taking XX XX tablets at a time for pain control. XX previous XX injection was mostly ineffective in controlling symptoms and XX could not obtain approval to receive physical therapy due to XX issues. The examination showed severe tenderness to palpation over the XX aspect of the XX, XX to the XX groove. XX range of motion showed passive forward XX of XX degrees, XX of XX degrees, and external rotation with the XX at side to XX degrees. XX could internally rotate to the XX level. XX had XX/5 XX strength with significant pain, XX/5 external rotation strength with the XX at the side. XX had a positive XX tests. XX XX and XX XX strength were measured as XX/5. On XX,

XX. XX had a physical therapy re-evaluation by XX. XX stated that XX went to see XX physician after XX previous physical therapy session on XX as XX felt XX XX was not getting better. XX had received an injection on XX but reported that the pain was not any better and had returned to physical therapy. On examination, the XX XX range of motion on XX was XX degrees, XX 90 degrees, and internal rotation XX degrees. The XX XX active range of motion on XX was XX degrees, XX XX degrees, external rotation XX degrees and internal rotation XX degrees. The XX XX passive range of motion on XX was XX degrees, external rotation XX degrees and internal rotation XX degrees. The XX XX XX strength was measured as XX+ on XX XX, external and internal rotation and XX on XX XX. The XX XX pain was rated as XX/10. XX scored XX% disability on disabilities of the XX, XX, and XX (XX). Per a utilization review determination letter by XX dated XX, the request for additional XX sessions of physical therapy were not certified. It was determined that XX. XX had XX certified post-operative physical therapy visits for the XX XX. XX was noted to have had XX sessions of physical therapy and fax indicated there were XX remaining authorized visits approved through XX. However, there was limited documentation of functional improvement with the previously-attended physical therapy sessions. Further therapy visits were not indicated until all previously-authorized sessions had been completed with noted re-evaluation and demonstration of continued deficits. Therefore, the requested additional physical therapy XX sessions for the XX XX was not medically necessary. A letter dated XX by XX indicated that the reconsideration request was denied / non-certified. There was a previous determination, which was non-certified. In the case, XX. XX underwent a XX repair and XX XX on XX. As of XX physical therapy (PT) note, the range of motion (ROM) had improved from preoperative to XX XX degrees, XX to XX degrees, external rotation XX degrees and internal rotation XX degrees, although XX felt that XX was not doing well and having more pain. Per the prior adverse determination, XX. XX had already received the maximum XX visits recommended by Official Disability Guidelines for post-XX surgery. The number of visits actually done was unknown. Without that information, the request could not be determined to be medically necessary or appropriate. Per an addendum note with the XX, a successful peer-to-peer call with XX was made. The details of the request were discussed. XX, who expressed great XX with the process of getting proper freshmen for XX. XX who has had therapy delayed many times secondary to insurance company XX. As a result, XX had developed adhesive XX for which XX required aggressive treatment. The range of motion (ROM) greatly limited with XX stabilized XX of XX degrees and internal rotation of XX degrees. Therefore, the requested appeal for additional physical therapy over XX sessions on the XX XX for the frozen XX was certified. X-ray of the XX XX dated XX was unremarkable. An MRI of the XX XX dated XX revealed a superior XX XX and XX (XX) tear with minimal XX extension to the XX XX suspicious for a XX type XX tear. There was XX XX near full-thickness tear of the XX XX that extended from the XX surface superiorly to the XX surface at the mid-XX. Office visit note dated XX indicates that the patient has been doing well. XX previous XX injection was mostly ineffective in controlling XX symptoms. On physical examination XX has severe tenderness to palpation over the XX aspect of the XX XX to the XX groove. XX range of motion is passive forward flexion XX, passive XX of XX, passive ER with the XX at the side to XX degrees. XX has XX/5 XX strength, XX/5 ER strength, positive XX. Treatment to date consisted of medications, physical therapy, and XX injections (mostly ineffective).

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 Additional physical therapy XX sessions for the XX XX is not recommended as medically necessary, and the previous denials are upheld. Per a utilization review determination letter by XX dated XX, the request for additional XX sessions of physical therapy were not certified. It was determined that XX. XX had XX certified post-operative physical therapy visits for the XX XX. XX was noted to have had XX sessions of physical therapy and fax indicated there were XX remaining authorized visits approved through XX. However, there was limited documentation of functional improvement with the previously-attended physical therapy sessions. Further therapy visits were not indicated until all previously-authorized sessions had been completed with noted re-evaluation and demonstration of continued deficits. Therefore, the requested additional physical therapy XX sessions

for the XX XX was not medically necessary. A letter dated XX by XX indicated that the reconsideration request was denied / non-certified. There was a previous determination, which was non-certified. In the case, XX. XX underwent a XX repair and XX XX on XX. As of XX physical therapy (PT) note, the range of motion (ROM) had improved from preoperative to XX XX degrees, XX to XX degrees, external rotation XX degrees and internal rotation XX degrees, although XX felt that XX was not doing well and having more pain. Per the prior adverse determination, XX. XX had already received the maximum XX visits recommended by Official Disability Guidelines for post-XX surgery. The number of visits actually done was unknown. Without that information, the request could not be determined to be medically necessary or appropriate. Per an addendum note with the same date, a successful peer-to-peer call with XX was made. The details of the request were discussed. XX, who expressed great frustration with the process of getting proper freshmen for XX. XX who has had therapy delayed many times secondary to insurance company XX. As a result, XX had developed adhesive XX for which XX required aggressive treatment. The range of motion (ROM) greatly limited with XX stabilized XX of XX degrees and internal rotation of XX degrees. Therefore, the requested appeal for additional physical therapy over XX sessions on the XX XX for the XX XX was certified. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient has been authorized for at least XX postoperative physical therapy visits. 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. 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 as directed by the guidelines. Therefore, the request is not medically necessary and upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES