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Notice of Independent Review Decision

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
X

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

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

X Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
X

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a X whose date of injury is X. The patient underwent X on X and has completed X to date. Per Dr. X on X, it is noted that the patient is making progress,

and X would like to try more strengthening activities at physical therapy. The physical examination reveals good active and passive range of motion of the right shoulder. X has pain with cross body adduction and internal rotation, particularly with resistance. The assessment is right shoulder X. The treatment plan is to continue to work on strengthening and return back in 1 month. Per the X physical therapy report by X, PT, DPT, the patient is being seen for visit number X. The patient presents to physical therapy secondary to right biceps X performed on X. The patient states X has been using the shoulder sling as instructed by X physician, as well as an ice machine. The patient reports X is still having difficulty with functional limitations including lifting weighted objects, overhead activities, dressing, daily hygiene, and X ability to return to X occupation at this time. On the physical examination, flexion is 140 degrees and abduction is 110 degrees. Strength has improved since X, from 3-3+/5 to 4/5. The patient has constant catching in the shoulder especially when X is over 90 degrees. It is noted that the patient should continue with physical therapy. Office visit note dated X indicates that overall X has basically plateaued. It has been two months since X last had therapy. X works as a flight attendant and has to do some heavy pushing and pulling. X has been trying to exercise at home but X has not really been able to progress to increase X lifting. On exam X has good range of motion. Strength of the rotator cuff is 4+ to 5-/5.

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 **X** is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that the Official Disability Guidelines recommend 24 visits over 14 weeks following shoulder surgeries. Within the documentation provided for review, the patient underwent a right biceps X on X. Per the X physical therapy record, the patient has had at least X to date. The patient has made improvements in strength with prior therapy. The patient still has limitations affecting X activities of daily living and return to work. However, the requested X exceed the guideline recommended duration. There is no documentation contraindicating a self-directed home exercise program to address any ongoing deficits. The denial was upheld on appeal noting that the prior treatment has included X followed by a home exercise program. The provider notes there has been a plateau since initiation of the home exercise program after completion of formal therapy. There were no exceptional factors that would support authorization of X. There is insufficient information to support a change in determination, and the previous non-certifications are upheld. The patient underwent X on X and has completed X to date. Current evidence based guidelines support up to 24 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. Therefore, based on the clinical information provided, the request for **X**

is not recommended as medically necessary.

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

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES