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Notice of Independent Review Decision

Amendment – Conflict of interest language included, ODG Guideline information noted and conclusion statement amended – October 15, 2007

DATE OF REVIEW: SEPTEMBER 12, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97750	Functional Capacity Evaluation	8 units	\$280.00
99212	Office Visit	1 unit	43.00
99212	Office Visit	1 unit	43.00
95851	Physical Performance Evaluation	3 units	150.00
95851	Physical Performance Evaluation	3 units	150.00
97750	Functional Capacity Evaluation	12 units	420.00
99453	Impairment rating	WP V4	425.00

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

Doctor of Chiropractic licensed in the State of Texas.

REVIEW OUTCOME

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

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Functional Capacity Evaluation	97750	08/25/06	Overturned
Office Visit	99219	08/28/06	Overturned
Office Visit	99212	08/30/06	Overturned
Physical Performance Evaluation	95851	10/04/06	Overturned
Physical Performance Evaluation	95851	11/16/06	Overturned
Functional Capacity Evaluation	97750	10/10/06	Overturned
Impairment rating V4 WP	99453	01/10/07	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Record Description	Record Date
Emergency Department radiology report and nurses notes Memorial Hospital	
Consultation visit –Orthopaedics –MD	05/27/05
Functional Capacity Evaluation –DC	10/06/05
Functional Capacity Evaluation report –DC	10/10/05
Office Visit notes –DO	10/20/05
Required Medical Evaluation & TWCC 69 DO	11/09/05
Peer review regarding medical necessity of all medical modalities and FCE. MD	12/28/05
Notice of Utilization Review findings – Right Shoulder open repair of rotator cuff – Guidelines or criteria not included in determination - Forte	05/31/06
Notice of Utilization Review findings – Outpatient physical therapy – CMS guidelines with criteria utilized included in determination - Forte	07/17/06
Notice of Utilization Review findings - Outpatient chiropractic therapy – Guidelines or criteria not included in determination –	09/06/06
Peer review findings for medical necessity of chiropractic care and FCE DC	09/28/06
Office Visit notes –Chiropractic	09/27,29/06 & 10/02,03/06
Office Visit & CMT documentation –Chiropractic	10/10/06
Notice of Utilization Review Findings – Outpatient work hardening - Specific guidelines not included in determination. Spine journal criteria included in determination -	10/17/06
Computerized Muscle Testing documentation – Gonzales Chiropractic	11/16/06
Notice of Utilization Review Findings - Outpatient work hardening – ODG guideline included in determination / Criteria not included in determination –	12/05/06
Work Hardening progress notes –DC	12/6/06 – 12/12/06
Work Hardening progress notes –DC	12/13/06 – 12/19/06
Work Hardening progress notes –DC	12/20/06 – 12/21/06
Peer review regarding the reasonableness and medical necessity of treatment, testing, referrals, medication, surgery –MD	12/11/06
Explanation of benefits for date of service 11/16/06 –Insurance	12/12/06
Office Visit - Impairment rating & TWCC 69 –DC	01/10/07
Review of medical history and physical exam –MD	01/18/07
Explanation of Benefits for dates of service 08/25/06 – 01/10/07 –Insurance	02/09/07
Itemized billing statement for dates of service 08/07/06 – 01/10/07 –Chiropractic	03/09/07

PATIENT CLINICAL HISTORY (SUMMARY):

At your request I have reviewed the available medical records pertaining to the above-captioned claimant, at which time an IRO was performed for medical necessity for pre-operative therapy, computer muscle testing, FCEs, post-operative therapy, work hardening and whole person impairment rating.

According to the records, the claimant injured his right shoulder while attempting to turn over a beam while at work. He went to the local emergency room and was examined, x-rays performed, medications prescribed and released. On 05-27-05, he sought care with Dr. who examined him, reviewed the x-rays, prescribed medications and ordered an MRI. On 06-29-05, an MRI of the right shoulder was performed with significant findings including a full thickness tear involving the rotator cuff. Dr. upon reviewing the MRI results recommended surgery to the right shoulder. However, the claimant decided to change treating doctor and sought care with Dr..

On 08-26-05, Dr. examined the claimant and recommended a trial treatment with conservative physical therapy. On 10-06-05, a FCE was performed with indications of the claimant meeting a light PDL and his occupational demands were medium PDL. On 10-17-05, the claimant indicated his pain was 20% reduced to the treatment. On 10-20-05, Dr. referred the claimant to Dr. an orthopedic surgeon. Dr. examined the claimant, reviewed the past treatment, x-rays, MRI and recommended surgery. On 11-09-05, the claimant

was sent to a Designated Doctor Examination with Dr. who indicated the claimant was not at maximum medical improvement. On 11-16-05, the claimant underwent surgical repair to his right shoulder condition. On 01-19-06, Dr. released the claimant for post-operative therapy at 3 times a week for 4 weeks. On 01-23-06, Dr. performed a computerized muscle testing. On 03-10-06, the claimant was sent for a repeat MRI and arthrogram to his right shoulder due to complications in his recovery, which revealed significant findings to several tendons. On 06-13-06, the claimant underwent a 2nd surgical repair of the right shoulder with Dr. an orthopedic surgeon. The claimant subsequently began post-operative physical therapy. On 07-17-06, the claimant was again sent to a Designated Doctors Examination with Dr. and again indicated the claimant was not at maximum medical improvement. On 07-27-06, the claimant continued his rehabilitation through 08-28-06. On 10-10-06 the claimant underwent a FCE evaluation. On 11-16-06 the claimant underwent a computerized muscle test. Approximately the end of November 2006, the claimant began work hardening which continued through 12-21-06. On 01-10-07, Dr. performed a final FCE and calculated 11% whole person impairment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

In conclusion, it appears from the evidence base medicine, the ODG Guidelines and the records submitted, Dr. has treated this claimant within the guides. As noted in the guides cited above, "Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months." Dr. did follow these protocols.

Therefore, this denial is over-turned completely and is considered medically necessary, reasonable and supported by the Guides cited above.

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

According to the ODG guides, exercises are recommended. Shoulder disorders may lead to joint stiffness more often than other joint disorders. Therapeutic exercise, including strengthening, should start as soon as it can be done without aggravating symptoms. Pendulum exercises are usually tolerated by the patient even when discomfort is pronounced, and range of motion can be preserved by this method. Lifting and working at 90 degrees (the position of abuse) as well as overhead work should be proscribed or restricted during the first few weeks after onset of problems due to acute rotator cuff tear, AC joint strain or separation, and impingement syndrome. ([Verhagen-Cochrane, 2004](#)) Exercise was demonstrated to be effective in terms of short term recovery in rotator cuff disease, and longer term benefit with respect to function. Combining mobilization with exercise resulted in additional benefit when compared to exercise alone for rotator cuff disease. When compared to exercises, ultrasound is of no additional benefit over and above exercise alone. Supervised exercise regime is of benefit in the short and long term for mixed shoulder disorders and rotator cuff disease. ([Green-Cochrane, 2003](#)) ([Michener, 2004](#)) ([de Jager, 2004](#)) ([Grant, 2004](#)) For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. ([Carette, 2003](#)) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. ([Sauers, 2005](#)) Compared to the previous review there is even more evidence about the effectiveness of exercises, but limited evidence in favor of ergonomic interventions. ([Verhagen, 2006](#)). The same guides indicate physical therapy is also recommended. Positive (limited evidence). See also specific physical therapy modalities by name. For impingement syndrome significant results were found in pain reduction and isodynamic strength. ([Bang, 2000](#)) ([Verhagen-Cochrane, 2004](#)) ([Michener, 2004](#)) There is poor data from non-controlled open studies favouring conservative interventions for rotator cuff tears, but this still needs to be proved. Considering these interventions are less invasive and less expensive than the surgical approach, they could be the first choice for the rotator cuff tears, until we have better and more reliable results from clinical trials. ([Einisman-Cochrane, 2004](#)) Self-training may be as effective as physical therapist-supervised rehabilitation of the

shoulder in post-surgical treatment of patients treated with arthroscopic subacromial decompression. ([Anderson, 1999](#)) For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. ([Carette, 2003](#)) Use of a home pulley system for stretching and strengthening should be recommended. ([Thomas, 2001](#)) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone. Laser therapy is an effective single intervention when compared with placebo treatments, but adding laser treatment to therapeutic exercise did not improve treatment efficacy. The limited data available do not support the use of ultrasound as an effective treatment for reducing pain or functional loss. Two studies evaluating the effectiveness of acupuncture produced equivocal results. ([Sauers, 2005](#)) Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultra-sonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapists available for referral. ODG Physical Therapy Guidelines –Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#). Adhesive capsulitis: 16 visits over 8 weeks Rotator cuff syndrome/Impingement syndrome: Medical treatment: 10 visits over 8 weeks Post-surgical treatment, arthroscopic: 24 visits over 14 weeks Post-surgical treatment, open: 30 visits over 18 weeks Dislocation of shoulder: 12 visits over 12 weeks Acromioclavicular joint dislocation: AC separation, type III+: 8 visits over 8 weeks Sprains and strains of shoulder and upper arm: 9 visits over 8 weeks Sprained rotator cuff: Medical treatment: 10 visits over 8 weeks Post-surgical treatment: 24 visits over 14 weeks Brachial plexus lesions: Medical treatment: 14 visits over 6 weeks Post-surgical treatment: 20 visits over 10 weeks Fracture of humerus 18 visits over 12 weeks. Furthermore, the same Guides ODG in the shoulder chapter, under surgery for rotator cuff repair the guides indicate it is recommended as indicated below. Repair of the rotator cuff is indicated for significant tears that impair activities by causing weakness of arm elevation or rotation, particularly acutely in younger workers. However, rotator cuff tears are frequently partial-thickness or smaller full-thickness tears. For partial-thickness rotator cuff tears and small full-thickness tears presenting primarily as impingement, surgery is reserved for cases failing conservative therapy for three months. The preferred procedure is usually arthroscopic decompression, but the outcomes from open repair are as good or better. Surgery is not indicated for patients with mild symptoms or those who have no limitations of activities. ([Ejnisman-Cochrane, 2004](#)) ([Grant, 2004](#)) Lesions of the rotator cuff are best thought of as a continuum, from mild inflammation and degeneration to full avulsions. Studies of normal subjects document the universal presence of degenerative changes and conditions, including full avulsions without symptoms. Conservative treatment has results similar to surgical treatment but without surgical risks. Studies evaluating results of conservative treatment of full-thickness rotator cuff tears have shown an 82-86% success rate for patients presenting within three months of injury. The efficacy of arthroscopic decompression for full-thickness tears depends on the size of the tear; one study reported satisfactory results in 90% of patients with small tears. A prior study by the same group reported satisfactory results in 86% of patients who underwent open repair for larger tears. Surgical outcomes are much better in younger patients with a rotator cuff tear, than in older patients, who may be suffering from degenerative changes in the rotator cuff. Referral for surgical consultation may be indicated for patients who have: Activity limitation for more than three months, plus existence of a surgical lesion; Failure of exercise programs to increase range of motion and strength of the musculature around the shoulder, plus existence of a surgical lesion; Clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair; Red flag conditions (e.g., acute rotator cuff tear in a young worker, glenohumeral joint dislocation, etc.). Suspected acute tears of the rotator cuff in young workers may be surgically repaired acutely to restore function; in older workers, these tears are typically treated conservatively at first. Partial-thickness tears are treated the same as impingement syndrome regardless of MRI findings. Outpatient rotator cuff repair is a well accepted and cost effective procedure. ([Cordasco, 2000](#)) Difference between surgery & exercise was not significant. ([Brox, 1999](#)) There is significant variation in surgical decision-making and a lack of clinical agreement among orthopaedic surgeons about rotator cuff surgery. ([Dunn, 2005](#)) ODG Indications for Surgery™ -- Rotator cuff repair: Criteria for rotator cuff repair with diagnosis of full thickness rotator cuff tear AND Cervical pathology and frozen shoulder syndrome have been ruled out: 1. Subjective Clinical Findings: Shoulder pain and inability to elevate the arm; tenderness over the greater tuberosity is common in acute cases. PLUS 2. Objective Clinical Findings: Patient may have weakness with abduction testing. May also demonstrate atrophy of shoulder musculature. Usually has full passive range of motion. PLUS 3. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary views. AND Gadolinium MRI,

ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. Criteria for rotator cuff repair OR anterior acromioplasty with diagnosis of partial thickness rotator cuff repair OR acromial impingement syndrome (80% of these patients will get better without surgery.) 1. Conservative Care: Recommend 3 to 6 months: Three months is adequate if treatment has been continuous, six months if treatment has been intermittent. Treatment must be directed toward gaining full ROM, which requires both stretching and strengthening to balance the musculature. PLUS 2. Subjective Clinical Findings: Pain with active arc motion 90 to 130 degrees. AND Pain at night (Tenderness over the greater tuberosity is common in acute cases.) PLUS 3. Objective Clinical Findings: Weak or absent abduction; may also demonstrate atrophy. AND Tenderness over rotator cuff or anterior acromial area. AND Positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test). PLUS 4. Imaging Clinical Findings: Conventional x-rays, AP, and true lateral or axillary view. AND Gadolinium MRI, ultrasound, or arthrogram shows positive evidence of deficit in rotator cuff. ([Washington, 2002](#)) The same Guides under work hardening/work conditioning indicate it is recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. ([Schonstein-Cochrane, 2003](#)) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. ([CARF, 2006](#)) ([Washington, 2006](#)) See [Physical therapy](#) for the recommended number of visits for Work Conditioning. For Work Hardening see below. Criteria for admission to a Work Hardening Program: 1. Physical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. 2. A defined return to work goal agreed to by the employer & employee: a. A documented specific job to return to, OR b. Documented on-the-job training 3. The worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. 4. The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. 5. Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. Also, the same Guides under lower back, procedure summary, work hardening - fitness to return to work it states FCE's, Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. ([Lechner, 2002](#)) ([Harten, 1998](#)) ([Malzahn, 1996](#)) ([Tramposh, 1992](#)) ([Isernhagen, 1999](#)) ([Wyman, 1999](#)) Functional capacity evaluation (FCE), as an objective resource for disability managers, is an invaluable tool in the return to work process. ([Lyth, 2001](#)) There are controversial issues such as assessment of endurance and inconsistent or sub-maximum effort. ([Schultz-Johnson, 2002](#)) Little to moderate correlation was observed between the self-report and the Isernhagen Work Systems Functional Capacity Evaluation (FCE) measures. ([Reneman, 2002](#)) Inconsistencies in subjects' performance across sessions were the greatest source of FCE measurement variability. Overall, however, test-retest reliability was good and interrater reliability was excellent. ([Gross, 2002](#)) FCE subtests of lifting were related to RTW and RTW level for people with work-related chronic symptoms. Grip force was not related to RTW. ([Matheson, 2002](#)) Scientific evidence on validity and reliability is limited so far. An FCE is time-consuming and cannot be recommended as a routine evaluation. ([Rivier, 2001](#)) Isernhagen's Functional Capacity Evaluation (FCE) system has increasingly come into use over the last few years. ([Kaiser, 2000](#)) Ten well-known FCE systems are analyzed -- All FCE suppliers need to validate and refine their systems. ([King, 1998](#)) Compared with patients who gave maximal effort during the FCE, patients who did not exert maximal effort reported significantly more anxiety and self-reported disability, and reported lower expectations for both their FCE performance and for returning to work. There was also a trend for these patients to report more depressive symptomatology. ([Kaplan, 1996](#)) Safety reliability was high, indicating that therapists can accurately judge safe lifting methods during FCE. ([Smith, 1994](#)) Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if 1. Case management is hampered by complex issues such as: • Prior unsuccessful RTW attempts. • Conflicting medical reporting on precautions and/or fitness for modified job. • Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: • Close or at MMI/all key medical reports secured. • Additional/secondary conditions clarified. Do not proceed with an FCE if • The sole purpose is to determine a worker's effort or compliance. • The worker has returned to work and an ergonomic assessment has not been arranged. ([WSIB, 2003](#))

