

# P&S Network, Inc.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** March 11, 2008

**IRO CASE #:**

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

This case was reviewed by an orthopedist, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Physical therapy, 12 sessions

### **REVIEW OUTCOME**

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

Overtaken (Disagree)

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o January 11, 2008 through February 5, 2008 peer review reports
- o June 20, 2007 through January 3, 2008 records from University Hospital including physical therapy notes, an operative report, and prescription sheets

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

According to the medical records, the patient sustained an industrial injury. According to a January 11, 2008 peer review report, the patient is a male who underwent right shoulder arthroscopy on June 28, 2007. He completed 16 sessions of postoperative therapy to date. He was seen for a follow-up on November 6, 2007. He continued to subjectively report weakness in the right shoulder and stated that he is unable to pick up a hammer in the mid ranges of motion. Examination findings included forward flexion to 160, abduction to 160, external rotation to approximately 40 compared to 75 on the contralateral side, and internal rotation to the lumbar spine compared to the thoracic spine on the contralateral side. Resisted forward flexion and external rotation revealed 4+/5 strength. There was 5/5 strength with resisted internal rotation. Incisions were well-healed and there were no signs or symptoms of infection. The peer review report states that the proposed additional therapy exceeds the recommended guidelines per ODG. The report opines that the patient has had sufficient formal therapy and should be capable of continuing to improve with a home exercise program.

The case was again reviewed on February 5, 2008 and a non-certification rendered. The report notes that the ODG guidelines recommend only 24 postoperative visits. The reviewer stated that there was no reference to strength on the January 3, 2008 note. The reviewing physician was not able to discuss the case with the requesting physician.

The records contain a June 28, 2007 operative report which outlines right shoulder arthroscopic rotator cuff repair and

subacromial decompression, right shoulder arthroscopic distal clavicle excision, and right shoulder arthroscopic biceps tendon tenodesis. An October 25, 2007 physical therapy final report states that the patient has done well in physical therapy. His passive range of motion has plateaued with 50 degrees of external rotation and 160 degrees of forward elevation. Active range of motion for forward elevation was 160 degrees. He continued to report soreness/achiness in his shoulder and his cuff strength was 3+ to 4 -/5, however, he continued to make strength gains as evidenced by his progression of therapy. The report notes that he still has room for improvement to progress in overhead strength.

A January 3, 2008 report states that the patient has had a total of 17 visits. The report notes that rehabilitation has been "a roller coaster over the last eight weeks." On December 18, 2008 the patient was much improved with 75 degrees of external rotation and less pain. On the date of the examination, he reported 8/10 pain and 60 degrees of external rotation. He had a painful arc of motion with overhead movements between 90 and 120 degrees, but did have 165 degrees of active forward elevation. The report states that the patient should continue with visits every other week of the next couple of months to regain the range of motion that he lost and hopefully improve his pain levels with scapular and humeral depressor strengthening.

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

The Official Disability Guidelines recommend post-surgical treatment for arthroscopic surgery for rotator cuff conditions and shoulder impingement to the 24 visits. The patient has had 17 visits to date and is therefore under the recommended range. In addition, the most recent documentation now demonstrates that this patient has deteriorated and has remaining functional deficits. He now complains of elevated pain levels as well. Given that he has not yet completed the recommended number of visits per the evidence-based guidelines and the remaining functional deficits, it is appropriate for him to continue with physical therapy at this time. Therefore, my determination is to overturn the previous non-certifications of 12 physical therapy visits.

The IRO's decision is consistent with the following guidelines:

**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 KNOWLEDGBASE

\_\_\_\_ AHCPR- 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 JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

\_\_\_\_ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

\_\_\_\_ MILLIMAN CARE GUIDELINES

x  ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

\_\_\_\_ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

\_\_\_\_ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

\_\_\_\_ TEXAS TACADA GUIDELINES

\_\_\_\_ TMF SCREENING CRITERIA MANUAL

\_\_\_\_ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

\_\_\_\_ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines (2008):

Physical therapy:

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Use of a home pulley system

for stretching and strengthening should be recommended. (Thomas, 2001) For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. The mainstays of treatment for instability of the glenohumeral joint are modification of physical activity and an aggressive strengthening program. Osteoarthritis of the glenohumeral joint usually responds to analgesics and injections into the glenohumeral joint. However, aggressive physical therapy can actually exacerbate this condition because of a high incidence of joint incongruity. (Burbank, 2008)

Impingement syndrome: For impingement syndrome significant results were found in pain reduction and isodynamic strength. (Bang, 2000) (Verhagen-Cochrane, 2004) (Michener, 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) 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)

Rotator cuff: 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. (Ejnisman-Cochrane, 2004)

Adhesive capsulitis: 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) Physical therapy following arthrographic joint distension for adhesive capsulitis provided no additional benefits in terms of pain, function, or quality of life but resulted in sustained greater active range of shoulder movement and participant-perceived improvement up to 6 months. (Buchbinder, 2007) Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, 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.

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

Complete rupture of rotator cuff (ICD9 727.61; 727.6)

Post-surgical treatment: 40 visits over 16 weeks

Adhesive capsulitis (IC9 726.0):

Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

Dislocation of shoulder (ICD9 831):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

Acromioclavicular joint dislocation (ICD9 831.04):

AC separation, type III+: 8 visits over 8 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Fracture of clavicle (ICD9 810):

8 visits over 10 weeks

Fracture of humerus (ICD9 812):

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

Work conditioning (See also Procedure Summary entry):

10 visits over 8 weeks