



IRO#
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DATE OF REVIEW: 05.15.2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

7 PT visits over 4 weeks - OT/PT unlisted therapeutic procedure

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

This case was reviewed by a Texas licensed DC, specializing in Chiropractic. The physician advisor has the following additional qualifications, if applicable:

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
7 PT visits over 4 weeks - OT/PT unlisted therapeutic procedure		-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	Initial Utilization Review		2	04/03/2008	04/03/2008
2	Appeal Utilization Review		2	04/28/2008	04/28/2008
3	Peer Review		4	04/01/2008	04/24/2008
4	Office Visit		3	03/12/2008	04/23/2008
5	Performance Evaluation		25	03/04/2008	03/04/2008
6	Office Visit		4	02/04/2008	02/27/2008

PATIENT CLINICAL HISTORY [SUMMARY]:

History: According to the data submitted (68 pages) the claimant injured herself on xx/xx/xx. No information of how the industrial accident occurred, what treatment has been performed for the past 9 years and the outcomes, nor the original diagnosis. From the documents the claimant a female was injured and has been treated throughout the years with all kinds of treatments and therapy. In February 2008 the claimant

underwent her 3rd set of trigger point injections to the right shoulder for adhesive capsulitis. On 03-04-08, she completed a physical performance evaluation of the entire body with minimal findings. No other data is available.

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

This claimant has had this therapy in the prior 9 years along with a plethora of other therapies, pharmaceutical interventions and injections. There is no information regarding an exacerbation, or the noted lack of data submitted which was already noted above. Therefore, the requested therapy of 7 visits over 4 weeks is not supported by the guides, nor is it considered medically necessary or reasonable.

Physical therapy for the elbows are recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. ([Handoll-Cochrane, 2003](#)) ([Handoll2-Cochrane, 2003](#)) During immobilization, there was weak evidence of improved hand function in the short term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. ([Handoll-Cochrane, 2002](#)) ([Handoll-Cochrane, 2006](#)) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ($p < 0.05$). ([Rapoliene, 2006](#))

ODG Physical/Occupational Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the [ODG Preface](#).

Fracture of carpal bone (wrist) (ICD9 814):

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of metacarpal bone (hand) (ICD9 815):

Medical treatment: 9 visits over 3 weeks

Post-surgical treatment: 16 visits over 10 weeks

Fracture of one or more phalanges of hand (fingers) (ICD9 816):

Minor, 8 visits over 5 weeks

Post-surgical treatment: Complicated, 16 visits over 10 weeks

Fracture of radius/ulna (forearm) (ICD9 813):

Post-surgical treatment: 16 visits over 8 weeks

Dislocation of wrist (ICD9 833):

Medical treatment: 9 visits over 8 weeks

Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks

Dislocation of finger (ICD9 834):

9 visits over 8 weeks

Post-surgical treatment: 16 visits over 10 weeks

Trigger finger (ICD9 727.03):

Post-surgical treatment: 9 visits over 8 weeks

Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):

Medical treatment: 12 visits over 8 weeks

Post-surgical treatment: 14 visits over 12 weeks

Synovitis and tenosynovitis (ICD9 727.0):

Medical treatment: 9 visits over 8 weeks

Physical therapy for the neck is recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapist, to avoid debilitation and further restriction of motion. ([Rosenfeld, 2000](#)) ([Bigos, 1999](#)) For mechanical disorders for the neck, therapeutic exercises have demonstrated clinically significant benefits in terms of pain, functional restoration, and patient global assessment scales. ([Philadelphia, 2001](#)) ([Colorado, 2001](#)) ([Kjellman, 1999](#)) ([Seferiadis, 2004](#)) Physical therapy seems to be more effective than general practitioner care on cervical range of motion at short-term follow-up. ([Scholten-Peeters, 2006](#)) In a recent high quality study, mobilization appears to be one of the most effective non-invasive interventions for the treatment of both pain and cervical range of motion in the acutely injured WAD patient. ([Conlin, 2005](#)) A recent high quality study found little difference among conservative whiplash therapies, with some advantage to an active mobilization program with physical therapy twice weekly for 3 weeks. ([Kongsted, 2007](#)) See also specific physical therapy modalities, as well as [Exercise](#).

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](#).

Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0):

9 visits over 8 weeks

Sprains and strains of neck (ICD9 847.0):

10 visits over 8 weeks

Physical therapy for the shoulder is 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](#)) ([Burbank2, 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

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

ODG:

shoulder, neck, hand/wrist/forearm, procedure summary, physical therapy