



## Notice of Independent Review Decision

### **IRO REVIEWER REPORT**

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**DATE OF REVIEW:** 7/8/09      **Date Amended:** 7/10/09

**IRO CASE #:**                      **NAME:**

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

Determine the appropriateness of the previously denied request for 12 physical therapy (aquatic) sessions (CPT codes 97113, 97140, G0283 and 97035).

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

Texas licensed Chiropractor.

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The previously denied request for 12 physical therapy (aquatic) sessions (CPT codes 97113, 97140, G0283 and 97035).

There were no guidelines provided by the URA for this referral.

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender:** Female

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** Lifting injury.

**Diagnosis:** Rotator cuff syndrome, adhesive capsulitis, muscular deconditioning, and myofascial pain syndrome.

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

The claimant is a female who was involved in a work related injury on Xx/xx/xx. The injury was described as the claimant was picking up bed sheets when she noted pain in her neck, right shoulder, and arm. On 12/29/2007, the claimant was evaluated by Dr. , an orthopedist. The recommendation was for differential injections, as well as therapeutic injections to the subacromial space with corticosteroid and lidocaine. There was also a recommendation for a cervical spine MRI. On 12/17/2007, the claimant underwent a right shoulder MRI. This revealed a 1.0 cm full thickness tear of the distal supraspinatus tendon with retraction of the musculotendinous junction, Type III acromion, and degenerative joint disease in the glenohumeral joint. On 4/9/2009, the claimant presented to the office of Dr. DC, for an initial evaluation. At that time, the claimant complained of right shoulder pain rated 8/10 on the visual analogue scale. The report indicated the claimant's condition had deteriorated despite participating in a home exercise program. The claimant was diagnosed with rotator cuff syndrome, adhesive capsulitis, muscular deconditioning, and myofascial pain syndrome. A request for 12 sessions of therapy consisting of therapeutic exercise and aquatic therapy was submitted. Treatment was also to include massage therapy, interferential therapy and joint mobilization. On 5/4/2009, this request went to peer review and was denied. On 5/22/2009, this request went to an appeal and was again denied by peer review. To date, the claimant has not received any treatment with his current provider. The purpose of this review is to determine the medical necessity for the requested 12 aquatic therapy treatments. The medical necessity for the requested 12 physical therapy treatments was not established. The 12/29/2007 orthopedic evaluation with Dr., indicated the claimant complained of right shoulder and neck pain. It was reported that the claimant did undergo a course of physical therapy that "did not improve her symptoms." The 5/7/2009, a subsequent evaluation noted the claimant had a contested case hearing (CCH) in April 2009, that indicated the shoulder injuries were considered compensable. The claimant did have significant clinical findings on MRI. A brief course of active, land-based physical therapy could be considered appropriate. However, the request is for aquatic therapy. There was no indication that the claimant would require aquatic therapy over a land-based program. The ODG web-based version, Pain chapter gives the following recommendations regarding aquatic therapy: "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme

obesity." This suggests that aquatic therapy may be an alternative to land-based physical therapy. However, there was no rationale why this claimant cannot participate in a land-based program as opposed to aquatic program. Therefore, the determination from this IRO review must be to uphold the previous denial of the requested 12 physical therapy (aquatic) treatments.

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

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE.
- 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.**

Official Disability Guidelines (ODG) web-based version, Shoulder and Pain.  
ODG, web-based version, Pain-aquatic therapy: *"Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity."*

ODG, Shoulder-Physical Therapy. *"Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks."*

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND PRACTICE PARAMETERS.
- TEXAS TACADA GUIDELINES.
- TMF SCREENING CRITERIA MANUAL.
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION).

□ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION).