



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 4/19/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of physical therapy 3 times per week for 4 weeks for the right shoulder (97032, 97110, 97140).

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

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 15 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of physical therapy 3 times per week for 4 weeks for the right shoulder (97032, 97110, 97140).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Coventry Health Care WC and, MD

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Coventry: Denial letters – 2/22/10, 3/5/10, 3/12/10, & 3/19/10; Medicine Center Request for Outpatient PT – 2/17/10-3/12/10; Regional Hospital notes – 2/16/10, and Patient Information Sheet – undated.

Records reviewed from, MD: Progress Notes – 1/27/10-2/11/10, Office Notes – 1/27/10 & 2/11/10, PT Request – 2/11/10 & 3/2/10, various DWC73s; , MD MRI right shoulder – 2/5/10; and Regional Hospital MRI script – 1/27/10.

We did not receive a copy of the ODG Guidelines from the Carrier or URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

The 2-22-10 dated denial letter denoted the claimant's ongoing right shoulder pain, subjective weakness, and stiffness. Exam findings revealed that the right shoulder had flexion and abduction to 160°. A prior MRI has revealed rotator cuff inflammation/partial tear. There was noted to not have been any valid rationale provided that would support ongoing supervised therapy. The 3-5-10 dated letter of reconsideration was reviewed and the therapy request had been noted to exceed guidelines. The 3-12-10 dated letter referenced "adhesive capsulitis" with motion limited to 35 degrees on 1-27-10. Flexion of 90 degrees was noted on 2-16-10, the date on which abduction was noted to be to 70 degrees. 18 therapy visits were recommended. Certain therapy modalities were not considered appropriate for certification, as per the reviewer.

Therapy records were reviewed, including from dates above, with abduction and flexion corresponding to the 3-12-10 dated letter that referenced the therapy record from 2-16-10.

AP records from 2-11-10 and 1-27-10 noted the indication for therapy and adhesive capsulitis diagnosis. The 2-5-10 dated MRI of the affected shoulder was noted.

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

The claimant's subnormal functionality and markedly limited motion is compatible with multiple diagnoses including rotator cuff tear and adhesive capsulitis. ODG guidelines support more therapy (16 visits) than the 10 visits associated solely with medical treatment of cuff tears. Therefore, the AP's request is considered medically necessary considering the magnitude of motion, strength and associated functionality deficit in this "frozen shoulder" adhesive capsulitis setting.

Reference: ODG Guidelines- Shoulder

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

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 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
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)