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**Notice of Independent Review Decision
Notice of Independent Medical Review Decision
Reviewer's Report**

DATE OF REVIEW: August 17, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of occupational therapy including therapeutic exercises (CPT code 97110), manual therapy (CPT code 97140), and electrical stimulation (CPT code 97014).

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

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)

Ten sessions of occupational therapy involving therapeutic exercises (CPT code 97110) and manual therapy (CPT code 97140) are medically necessary. Electrical stimulation (CPT code 97014) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 7/27/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 7/28/10.
3. TDI Notice to IRO of Case Assignment dated 7/28/10.
4. Medical records from Orthopaedic Surgery Group and Center for Sports Medicine dated 7/7/10, 6/30/10, 5/19/10, and 4/27/10.
5. Impairment Rating from, PC dated 3/30/10.
6. MRI report of left shoulder without contrast dated 4/8/10.
7. Denial documentation.
8. Physician Review Recommendation Prepared for dated 7/23/10 and 7/16/10.
9. Report from, Inc. dated 5/12/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained a left shoulder injury on xx/xx/xx. An MRI of the shoulder was performed on 4/8/10, which showed a possible small supraspinatus tear as well as supraspinatus tendinopathy. The patient underwent a physical therapy evaluation on 4/27/10. During this session, the therapist noted that the patient had 2/5 shoulder strength as well as abduction to only 68 degrees. The therapist's plan consisted of multiple techniques including manual techniques, joint mobilization, and therapeutic exercises. Authorization has been requested for 10 sessions of occupational therapy consisting of therapeutic exercises (CPT code 97110), manual therapy (CPT code 97140), and electrical stimulation (CPT code 97014). Subsequent to the request for authorization for occupational therapy, the patient underwent a corticosteroid/analgesic injection to his left shoulder on 6/30/10.

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

Per Official Disability Guidelines (ODG) for sprained shoulder/rotator cuff (ICD 840.04), 10 therapy sessions (over 8 weeks) is considered appropriate treatment. Also per ODG guidelines with regard to active versus passive modalities: "The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). 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 therapy providers available for referral."

As noted above, there is a lack of adequate outcome data supporting the efficacy of the passive modality of electrical stimulation in this setting. However, the use of therapeutic exercises (CPT code 97110) and manual therapy (CPT code 97140) is the standard of care in this setting, is consistent with ODG guidelines and is medically necessary for treatment of the patient's shoulder injury.

In conclusion, I have determined that 10 occupational therapy visits over 8 weeks with the use of therapeutic exercises (CPT code 97110) and manual therapy (CPT code 97140), but without the use of electrical stimulation (CPT code 97014) are medically necessary for this patient.

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)