



Notice of Independent Review Decision  
**IRO REVIEWER REPORT**

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**DATE OF REVIEW:** 7/6/10

**IRO CASE #:**

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

Determine the appropriateness of the previously denied request for 8 additional sessions of right shoulder physical therapy including CPT codes: 97001, 97110, 97112, 97140 and 97530.

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

Texas licensed orthopedic surgeon

**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 8 additional sessions of right shoulder physical therapy including CPT codes: 97001, 97110, 97112, 97140 and 97530.

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

**PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender:** Female

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

**Mechanism of Injury:** Lifting a 70 pound child.

**Diagnosis:** Subacromial bursitis and rotator cuff tendonitis.

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

This female was injured on xx/xx/xx. The mechanism of injury occurred while lifting a 70-pound child, she felt an onset of right arm pain in the right deltoid and right bicep areas. The diagnoses were subacromial bursitis and rotator cuff tendonitis. She first attempted conservative treatment with ice and Ibuprofen. When seen on xxxxx, it was noted that she had not benefited from that treatment. She indicated that, overall, the arm did not feel normal. She was

not able to use it normally. There was no pain in the neck, back or in the shoulder proper. The physical examination, by Dr., noted possible biceps tendon tenderness and deltoid muscle diffuse tenderness with painful limited range of motion with attempts at overhead, extension with internal rotation, and adduction. The assessment was biceps tendonitis and deltoid muscle strain. The patient was given work restrictions, exercises, and Ibuprofen 800 mg three times a day and a Toradol shot 60 mg x 1. The patient followed withxxxxx, and on March 8, 2010, in follow-up, it was noted that the arm pain had not improved, and she was now having shooting pains in the neck down into the arm with treatment. The physical examination noted tenderness at the biceps tendon, otherwise there was good motion of the arm and normal motion in the neck. The patient was to continue conservative treatment and requested orthopedic consultation. On March 15, 2010, Dr. evaluated the patient, noting the prior history. He noted the patient was intermittently taking Ibuprofen. The physical examination of the right upper extremity noted no acromioclavicular (AC) tenderness, slight bicipital grooves, and greater tuberosity tenderness. Neer was painful but there was no pain with Hawkins. There was full motion with the exception of about two levels of loss of internal rotation. There was pain over about 110 degrees. Good rotator cuff strength was noted with slight pain on resisted abduction and external rotation. Early AC joint arthrosis was noted on conventional radiographs. Straightening of the cervical spine was noted. The plan, at that time, was formal physical therapy and consideration for corticosteroid injection, which was performed. The patient had been in physical therapy beginning on April 2, 2010. A May 21, 2010 report indicated that 12 PT sessions were attended. Continued weakness in both right and left, abduction on the right limited by pain and/or guarding at 4-/5 and left 3+/5 were noted. Shoulder extension was 4 bilaterally. Shoulder flexion: Right again limited by pain and/or guarding at 4- and left was 3+. External rotation: Right limited by pain and/or guarding at 3+ and left 4-; internal rotation 4 bilaterally, and elbow flexion 4+ as was extension bilaterally. The range of motion active, left 155 and right 130 and passively right 165. Abduction with pain was noted on the right at 100 and left 142. There was also pain on flexion on the right. The patient's cervical motion had 90% extension, 30% flexion, 60% rotation left with complaints of tightness on the right and 80% right. The "To whom It May Concern" letter indicated the recommendation for further therapy. It was felt that the patient was responding well and reported relief of symptoms. The most current report from Dr., dated May 19, 2010, indicated the patient felt some benefit but continued to have pain and requested an MRI, but the patient did not want surgery. The physical by Dr. xxxxx noted tenderness at AC joint with forward flexion, abduction with pain over about 90 degrees both, internal rotation limited to hip, and pain with behind the back maneuvers. There was pain with rotational maneuvers, Hawkins and Neer. The patient had decent rotator cuff strength against resistance. She wanted to continue physical therapy. The ODG recommends up to nine visits over 12 weeks and further deviation is not supported by the medical records. Therefore, the previous adverse determination is upheld and an additional 8 sessions of PT is not medically necessary.

**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.
- AHCPH – 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), Treatment Index, 8<sup>th</sup> Edition (web), 2010, Shoulder, Chapter Physical Therapy and Back Section.
- 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).