



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 03/19/10

**IRO CASE #:**

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

The services under dispute are physical therapy (3x4) to the right shoulder (97110).

**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 Physical Medicine and Rehabilitation. The reviewer performs this type of procedure in daily practice and 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 medical necessity of physical therapy (3x4) to the right shoulder (97110).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Bone and Joint (BBJ).

These records consist of the following (duplicate records are only listed from one source): BBJ: 7/30/09 radiographic report, 7/30/09 physical report by Dr. 8/4/09 right shoulder MRI report, daily notes by Dr. 8/6/09 to 2/16/10 and an operative report 9/30/09.

1/26/10 denial letter, 2/15/10 denial letter, 1/12/10 PT script and PT assessments dated 11/09 to 1/20/10.

We did not receive the ODG Guidelines from Carrier/URA.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a female who injured her right upper extremity xx/xx/xx while working as a. She continued to work for a time but shoulder pain increased. She was evaluated by M.D. X-rays of the shoulder were reported to show acromioclavicular joint arthropathy and a large subacromial spur. Dr. recommended a subacromial injection of Celestone and lidocaine.

On a follow-up visit 8/06/2009 Dr. noted that the injection had given temporary relief from the pain. He reviewed MRI findings of the right shoulder and discussed treatment options. The patient elected to proceed with arthroscopy and interval rotator cuff repair. On 9/30/2009 she underwent operative arthroscopy of the right shoulder with limited debridement, arthroscopic subacromial decompression and release of the coracoacromial ligament, and mini-open deltoid splitting rotator cuff interval repair of the right shoulder.

On 10/6/2009 she was instructed in some self-supervised passive range of motion exercises with limitations to 90 degrees of flexion, 45 abduction and neutral rotation. On 11/05/2009 the sling was removed and a program of active range of motion was started. On 12/08/2009, shoulder flexion was 90 degrees. External rotation was limited compared to the other side. Physical therapy was proceeding slowly. Dr. ordered another round of physical therapy. On 01/12/2010, Dr. noted that the patient "does have some degree of a frozen shoulder". She still lacked strength. Dr. felt that she was too deconditioned to do her job as a. He requested more physical therapy in an effort to get her range of motion and strength back. Follow-up in one month was recommended.

On 1/19/2010 Dr. noted that she was three months out from surgery and had not made much progress since the previous visit. On examination, shoulder flexion was 90 degrees, external rotation 20 degrees. Dr. recommended repeat MRI scan of the right shoulder and MRI scan of the cervical spine to rule out cervical radiculitis or a recurrent rotator cuff interval tear. The last submitted physical therapy note was handwritten, dated 1/20/2010. She reported pain during the evaluation and treatment.

On 2/4/2010 Dr. submitted a letter explaining that the patient was recovering from open rotator cuff surgery of the right shoulder and was progressing slowly in her rehabilitation efforts. He requested authorization for further physical therapy. On 2/16/2010 the patient returned for follow-up. She had made very slow progress in recuperation from the surgery and had limited range of motion. "Technically, she has a frozen shoulder". Dr. had requested MRI of the shoulder and of the cervical spine to rule out a ruptured cervical disc.

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

According to the ODG physical therapy guidelines for 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

The above described mini-open deltoid splitting rotator cuff interval repair of the right shoulder was an open procedure. Ms. received 24 treatments over 11 weeks from 11/6/2009 through 1/20/2010, whereas the physical therapy guidelines authorize 30 visits over 18 weeks for post-surgical treatment (open procedure).

Twelve additional visits (three times a week for four weeks), have been requested. Although the proposed therapy exceeds the “recommended” remaining amount, there has been a decrease in shoulder range of motion, documented in the January and February clinical notes, while awaiting authorization for further therapy. According to the ODG general guidelines pertaining to physical therapy:

- Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program...
- Within four visits, the patient must display documented improvement in order to continue therapy. If no improvement is noted, a comprehensive re-evaluation should be performed....
- Continued improvement must be documented for continued therapy. Typically no more than four to six visits are needed.
- Somewhere between 9 and 12 visits or between 4 and 6 weeks the patient should be reassessed.
- Generally, the number of weeks recommended should fall within a relatively cohesive time period, between date of first and last visit, but this time period should not restrict additional recommended treatments that come later, for example due to scheduling issues or necessary follow-up compliance with a home-based program.

The eight week gap in physical therapy treatments since January 20, 2010 constitutes a “scheduling issue” which may have interfered with ongoing assessments of compliance as well as upgrades to the home therapy program. Therefore, this program is medically necessary at this time.

**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)