

# P&S Network, Inc.

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## Notice of Independent Review Decision

### MEDICAL RECORD REVIEW:

**DATE OF REVIEW:** 09/28/2010

**IRO CASE #:**

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

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

PT 3 x 4 right shoulder 97014, 97150, 97010, 97140, 97110, 07112

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

(Upheld)

(Agree)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o 05-03-10 Medical report from Dr.
- o 05-03-10 DWC 73 from Dr.
- o 05-07-10 Initial PT Assessment report from A. S., PT
- o 05-10-10 Medical report from Dr. Long
- o 05-10-10 5-12, 5-14, 5-21, 5-26, 5-28, 6-2, 6-4, 6-9, 6-11, 6-18, 6-21, 6-25 PT notes
- o 06-25-10 PT progress note from A. S., PT
- o 05-24-10 Medical report with DWC 73 from Dr.
- o 06-03-10 Script for additional PT from Dr.
- o 06-14-10 Medical report with DWC 73 from Dr.
- o 06-28-10 Medical report with DWC 73 from Dr.
- o 06-28-10 Request for pre-authorization precertification from Dr.
- o 07-01-10 Initial Denial Determination from
- o 07-02-10 Shoulder MRI read by Dr.
- o 07-07-10 Nurse intake report from Dr.
- o 07-07-10 Orthopedic consultation report and letter from Dr.
- o 07-13-10 Medical report from Dr.
- o 07-19-10 Letter of medical necessity for PT from, PT
- o 07-19-10 Request for pre-authorization precertification from Dr.
- o 07-25-10 Peer Review from Dr.
- o 07-26-10 Reconsideration - Denial Determination from
- o 08-05-10 Fax cover note from Dr. re IRO form
- o 08-05-10 Request for IRO from the Claimant
- o 08-11-10 Medical report from Dr.
- o 09-04-10 Confirmation of Receipt of Request for IRO from TDI
- o 09-04-10 Notice to P&S of Case Assignment from TDI
- o 09-13-10 Carrier Submission from

## **PATIENT CLINICAL HISTORY (SUMMARY):**

According to the medical records and prior reviews the patient is a female employee who sustained an industrial injury to the right shoulder on xx/xx/xx.

The patient was initially examined by the current provider on May 3, 2010. She reported constant moderate burning shoulder pain that limits activity. She is using albuterol, Naproxen and Norco. She smokes cigarettes. She is 5', 7" and 190 pounds. Passive left shoulder abduction is to 80 degrees and Hawkin's sign is positive. Strength is 4/5. X-rays are unremarkable. She has tendonitis of the shoulder. She is provided treatment of oral anti-inflammatories including Lodine, Norco and referral to PT.

The patient was assessed in PT on May 7, 2010. She has a pain level of 3/10. She has pain with movements and overhead activities. Active right flexion is to 70 degrees, extension to 21 degrees, abduction to 82 degrees. Flexion and abduction and external rotation strength is 4+/5.

The patient was reevaluated on May 10, 2010. She is working light duty and making some progress with her injury in PT. Abduction is to 120 degrees. Medications are continued. She will use a Medrol Dosepak.

The patient was reevaluated on May 24, 2010. She has improved ROM with PT but some continuing symptoms in the upper arm worse with overhead activities. She is using Naproxen, Norco and Etodolac. Abduction is to 95 degrees. Strength is 5/5. Hawkin's sign is positive.

Physical examination of June 14, 2010 showed 160 degrees of abduction, minimal internal rotation, and a negative Hawkins' sign. Strength was graded as 4/5 and sensation was intact. She was given a prescription for Celebrex 200 mg one daily.

Examination of June 25, 2010 indicates the patient is doing well. She has good strength without pain with manual muscle testing. Recommendation is for an additional 12 sessions of PT.

The patient was reevaluated in June 28, 2010. She continues to have deficits with strength and ROM particularly with internal rotation, but she is making progress. Approval has finally been obtained for shoulder MRI. Right shoulder abduction is to 160 degrees. There is minimal internal rotation. The right shoulder is weaker than the left.

Left shoulder MRI performed July 2, 2010 was given impression: 1. Productive changes in the AC arch, with some T2 hyperintensities in the clavicle, probably from contusion and sprain. Grade I impingement of the supraspinatus. 2. Tendinosis of the supraspinatus. 3. Tenosynovitis of the long head of the biceps tendon."

An orthopedic consultation was provided on July 7, 2010. She incurred an external rotation injury to the right arm. She has complained of pain over the anterior glenohumeral joint line. She has been in PT for 6-7 weeks with little improvement. She has been doing light work. She describes constant pain of 8/10. She is using Celebrex, Norco, and albuterol MDI. She smokes half a pack daily. There is tenderness over the right AC joint. She has full passive ROM in abduction. She has active total elevation to 170 degrees. Impingement sign is positive. Speeds and O'Brien tests are positive. She has 4+/5 strength with drop arm test. She has external rotation to the level of the occiput, internal rotation to approximately L4. There is tenderness over the bicipital groove and none over the supraspinatus insertion. Recommendation is to continue PT. She was given a prescription. Flexeril and Visatril will be added. She will remain on light duty and return in 2 months. PT was requested as the patient is responding well and is not extremely symptomatic.

The patient was reevaluated in July 13, 2010. She was making progress with PT but has been denied additional PT. The orthopedics recommended additional PT and return in 6 weeks. She has regressed since discontinuing PT. She could benefit from a steroid injection. Abduction is to 160 degrees. Internal rotation is to the sacrum with pain. There is tenderness over the lateral and anterior aspect of the shoulder.

A peer review was conducted on July 25, 2010. She has been treated for tendonitis of the shoulder. She had a Toradol injection, Norco, etodolac, Celebrex a Medrol Dosepak and 12 sessions of PT. On June 14, 2010 she was noted to be making slow progress. She noted heartburn with Lodine. Hawkin's sign was negative. Strength was 4/5 and sensation normal. She reported pain of 3/10 in PT. On May 12, 2010 she reported feeling better and pain of 2/10 in PT. On May 14, 2010 she noted increased soreness and pain of 6/10. On May 17, 2010 she noted pain of 2/10. On May 26, 2010 she was doing much better until she had to pick up her son that AM. She noted pain as 6/10. On May 28, 2010 she was better with no pain. On June 2, 2010 she filed about 600 papers and her shoulder pain increased to 6/10. On June 9, 2010 she reported shoulder pain of 2/10 and she missed the last 2 sessions because her husband was in the hospital. The diagnosis is right shoulder strain. The MRI findings of impingement and tendinosis of the supraspinatus are disease of life findings. The finding in the clavicle is in all probability not related to the described mechanism of injury and is a degenerative change as well. The treatment has been reasonable. At this time the patient should be declared at MMI. No additional injections or therapy is needed. She was doing fine until she picked up her son. The reviewer cites ODG "degenerative changes" versus "acute trauma" from Initial Conservative treatment.

Additional PT notes are reviewed: On June 18, 2010 the patient reports she feels GERD symptoms with Celebrex. She is progressed to strengthening exercises for stabilization. She reports no pain after treatment. On June 21, 2010 she is doing good.

On June 25, 2010 she is doing well. She notes good strength with pain with manual muscle testing. She reports a pain level of 1/10 following treatment.

Request for PT 3 x 4 right shoulder 97014, 97150, 97010, 97140, 97110, 07112 was considered in review on July 1, 2010 with recommendation for non-certification. 22 pages of medical records and the PT notes were reviewed. The patient attended 12 sessions of PT for a sprained shoulder. On June 14, 2010 she had 160 degrees of abduction, minimal internal rotation and a

negative Hawkin's sign. Strength was 4/5 and sensation intact. Celebrex was prescribed. On June 25, 2010 the patient reported she was doing well. She noted good strength without pain for manual muscle testing. She was recommended an additional 12 sessions of PT. A peer discussion was attempted but not realized. There are no imaging reports. ODG supports 10 visits for her diagnosis. Electrical stimulation is not recommended by ODG. Cold packs could be supported for home use.

Note from the therapist dated July 19, 2010 states the patient needs additional therapy due the following objective factors measured on June 25, 2010: Active shoulder flexion is 155 degrees and abduction 106 degrees. ADL checklist is 68% versus normal 100%. Lysholm shoulder score is 54%. VAS scale is 2/10. Although she has functional ROM, she continues to have difficulty completing job responsibilities without pain and discomfort.

Request for reconsideration PT 3 x 4 right shoulder 97014, 97150, 97010, 97140, 97110, 07112 was considered in review on July 26, 2010 with recommendation for non-certification. Per the reviewer, 38 pages of records were reviewed. A peer discussion was attempted but not realized. Rationale for denial notes the patient has functional range of motion at this time and there are no exception factors of delayed recovery documented to support ongoing PT at this time. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

According to a fax noted from the patient dated August 5, 2010 the patient states although Dr. mentioned rotator cuff tears, the MRI did not note tears. The patient states she still has minimal internal rotation. The reviewers seem to think she is much better. She states she has been complying with the restrictions and still has pain and discomfort.

The patient was reevaluated on August 11, 2010. She has not improved. She has an orthopedic appointment pending. Further PT has been denied. She gets some relief with the meds. She is using Celebrex and Norco (60 count must last 30 days). Her examination is unchanged. She will follow-up in one month.

The carrier's position was outlined in a Defense Summary dated September 13, 2010 is reviewed: The carrier is responsible for medical benefits as a result of the compensable injury only. The carrier is not responsible for treatment as a result of ordinary diseases of life. According to the reviewer on July 25, 2010, based on the therapy notes, MRI findings and recent exam findings, no additional active treatment appears reasonable per ODG criteria...it is probably that the effects of the 4/30/10 right shoulder strain have resolved. The reviewer noted that not all of the requested modalities are supported as standard treatment modalities. Specifically 97014 (electrical stimulation), 97150 (group therapy), 97010 (hot and cold pack applications), 97140 (manual therapy) and 97112 (neuromuscular re-education) are not standard treatment modalities. Current guidelines state that electrical therapy is not recommended for use in the shoulder and the application of hot and cold packs are a modality recommended for home use. The clinic notes do not offer exceptional factors to justify excessive therapy. The reconsideration rationale for denial noted no exceptional factors of delayed recovery are documented to support ongoing PT at this time.

Request was made for an IRO.

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

ODG supports up to ten visits of PT for a shoulder sprain, and tendonitis of the shoulder. The patient has attended 12 visits with improvements (initial pain level was 3/10, active flexion was to 70 degrees, extension to 21 degrees, abduction to 82 degrees and flexion, abduction and external rotation strength was 4+/5). On June 14, 2010 the patient demonstrated 160 degrees of abduction, minimal internal rotation, and a negative Hawkins' sign. Strength was graded as 4/5 and sensation was intact. On June 28, 2010 right shoulder abduction is to 160 degrees, there is minimal internal rotation and the right shoulder is weaker than the left. MRI of July 2, 2010 showed, productive changes in the AC arch, with some T2 hyperintensities in the clavicle, probably from contusion and sprain, grade I impingement of the supraspinatus, tendinosis of the supraspinatus, and tenosynovitis of the long head of the biceps tendon. On July 7, 2010 the patient reports a high pain level to the specialist (7/10) and examination shows, tenderness over the right AC joint, full passive ROM in abduction, active elevation to 170 degrees, positive impingement signs, and strength of 4+/5 with drop arm test. External rotation was to the level of occiput and internal rotation to approximately L4. There was tenderness over the bicipital groove and none over the supraspinatus insertion. The provider feels she has regressed since stopping PT.

The peer reviewer stated the patient has a right shoulder strain that should have resolved by now and the MRI findings of impingement and tendinosis of the supraspinatus are disease of life findings. The first line reviewer opined she has realized maximum benefit from the recommended amount of PT and some of the passive modalities being used are not supported by ODG. Second line review denial notes she has functional range of motion at this time and there are no exception factors of delayed recovery documented to support ongoing PT at this time and the patient should be able to complete her rehabilitation with HEP.

The patient is approximately 4.5 months post injury. Imaging and clinical findings do not suggest a need for a surgery. The passive modalities requested would not be supported for a patient in the chronic stage of injury. On July 7, 2010, internal rotation is to approximately L4, which is not significantly deficient. At this time the patient should be well-versed in a home exercise program. The guidelines state that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As there are no exceptional factors of delayed recovery documented to support ongoing PT, and there are no documented contraindications to the patient's participation in HEP, it is recommended that the patient complete her rehabilitation in HEP versus additional supervised PT.

Therefore, my recommendation is to agree with the previous non-certification for PT 3 x 4 right shoulder 97014, 97150, 97010, 97140, 97110, 07112.

The IRO's decision is consistent with the following guidelines:

**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
- AHCP- 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

The Official Disability Guidelines 07-28-2010, Shoulder Chapter, Physical therapy:

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Use of a home pulley system for stretching and strengthening should be recommended. For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. The mainstays of treatment for instability of the glenohumeral joint are modification of physical activity and an aggressive strengthening program. Osteoarthritis of the glenohumeral joint usually responds to analgesics and injections into the glenohumeral joint. However, aggressive physical therapy can actually exacerbate this condition because of a high incidence of joint incongruity.

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

Complete rupture of rotator cuff (ICD9 727.61; 727.6)

Post-surgical treatment: 40 visits over 16 weeks

**GROUP THERAPY BILLING:**

The group therapy CPT code (97150) and the direct one-on-one 15-minute CPT code for therapeutic exercises (97110), are a mutually exclusive CCI code pair unless the "59" modifier is used.

97150 is the column one (primary component) code while 97110 is the column two (inclusive component) code unless we distinguish the performance to separate time allotments. This requires the group therapy and the one-on-one exercise therapy to occur in different sessions, separate encounters, or different timeframes occurring sequentially, not concurrently, that are distinct or independent from each other.

When this occurs, the therapist would bill for both group therapy and therapeutic exercises, appending the -59 modifier to the column two code, 97110. Without the -59 modifier, payment would be made only for the column one group therapy CPT Code, 97150 since the individual therapy (97110) code would be interpreted as the "type of procedure" employed during the group activity rather than as a sequential (before or after) and separate "individual" session. [The Multi-Disciplinary Academy of Affiliated Medical Arts at <http://www.maama.org/index.htm>]