



Medical Review Institute of America, Inc.
America's External Review Network

DATE OF REVIEW: August 31, 2010

IRO Case #:

Description of the services in dispute:

Preauthorization of 12 additional sessions of physical therapy

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a member of the American Orthopaedic Society, the American College of Surgeons, the American Academy of Orthopaedic Surgeons, the American Medical Association and the American Academy of Disability Evaluating Physicians. This reviewer has been in active practice since 1976.

Review Outcome

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

Upheld.

The requested 12 additional sessions of physical therapy are not medically necessary.

Information provided to the IRO for review

Records from State 8/18/10

Request for Independent Review Organization 8/18/10, 8 pages

, Letter of Denial, 7/13/10, 8/17/10, 2 pages

, Letter of Appeal, 8/14/10, 2 pages

, Letter of Denial, 7/13/10, 2 pages

Records From URA 8/19/10

, Appeal, 8/17/10, 2 pages

, Preauthorization Request

, Preauthorization, 7/12/10, 2 pages

Bone & Joint LLP, Progress Note, 7/2/10, 1 page

Action, Preauthorization Request, 7/2/10, 1 page

Action Physical Therapy, Evaluate and Treat, 1 page

Peer Review Report, 6/23/10, 2 pages

, Re-Evaluation/Progress Note, 6/21/10, 1 page

Bone & Joint LLP, Progress Note 6/3/10–6/17/10, 1 page
Bone & Joint LLP, Progress Note, 3/17/10–6/3/10, 1 page
Surgery Center, Operative Report, 4/13/10, 3 pages
Bone & Joint LLP, Progress Note, 3/17/10, 1 page
Bone & Joint LLP, Progress Note, 3/8/10–3/17/10, 1 page
Radiology Associates of, MRI Report, 3/10/10, 1 page

Patient clinical history [summary]

The patient is a male who suffered a left shoulder injury on xx/xx/xx. The injury occurred as a result of a motor vehicle accident. An MRI scan on 03/10/10 revealed rotator cuff tear and mild acromioclavicular degenerative joint disease. On 04/13/10, he underwent a surgical procedure including rotator cuff repair and subacromial decompression. Twenty-four sessions of post operative physical therapy have been provided. The patient's range of motion and strength are recorded as near full and normal. Additional supervised physical therapy has been requested for preauthorization.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

1. Is the requested preauthorization of 12 additional sessions of physical therapy medically necessary?

No. The requested 12 additional sessions of physical therapy are not medically necessary. The patient has been performing a home exercise program. Range of motion is reported near full and strength restoration appears to be near complete. There does not appear to be any extra ordinary need for additional supervised physical therapy. The prior denials of this request to provide additional supervised physical therapy in excess of that recommended in the ODG, 2010, shoulder chapter, appear to be appropriate and should be upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

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. (Thomas, 2001) 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 orthopedist 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. (Burbank, 2008) (Burbank2, 2008)

Impingement syndrome: For impingement syndrome significant results were found in pain reduction and isodynamic strength. (Bang, 2000) (Verhagen–Cochrane, 2004) (Michener, 2004) Self-training may be as effective as physical therapist-supervised rehabilitation of the shoulder in post-surgical treatment of patients treated with arthroscopic subacromial decompression. (Anderson, 1999) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone. Laser therapy is an effective single intervention when compared with placebo treatments, but adding laser treatment to therapeutic exercise did not improve treatment efficacy. The limited data available do not support the use of ultrasound as an effective treatment for reducing pain or functional loss. Two studies evaluating the effectiveness of acupuncture produced equivocal results. (Sauers, 2005)

Rotator cuff: There is poor data from non-controlled open studies favoring conservative interventions for rotator cuff tears, but this still needs to be proved. Considering these interventions are less invasive and less expensive than the surgical approach, they could be the first choice for the rotator cuff tears, until we have better and more reliable results from clinical trials. (Ejnisman–Cochrane, 2004) External rotator cuff strengthening is recommended because an imbalance between the relatively over strengthened internal rotators and relatively weakened external rotators could cause damage to the shoulder and elbow, resulting in injury. (Byram, 2009)

Adhesive capsulitis: For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, supervised physical therapy is of limited efficacy in the management of adhesive capsulitis. (Carette, 2003) Physical therapy following arthrographic joint distension for adhesive capsulitis provided no additional benefits in terms of pain, function, or quality of life but resulted in sustained greater active range of shoulder movement and participant-perceived improvement up to 6 months. (Buchbinder, 2007) Use of the Shoulder Dynasplint System (Dynasplint Systems, Inc., Severna Park, MD) may be an effective adjunct "home therapy" for adhesive capsulitis, combined with PT. (Gaspar, 2009)

Active Treatment versus Passive Modalities: See the Low Back Chapter for more information. 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.

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

Dislocation of shoulder (ICD9 831):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

Acromioclavicular joint dislocation (ICD9 831.04):

AC separation, type III+: 8 visits over 8 weeks

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1–2 visits over 1 week

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

Fracture of clavicle (ICD9 810):

8 visits over 10 weeks

Fracture of humerus (ICD9 812):

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 weeks

ODG, 2010, shoulder chapter, physical therapy passage