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**Notice of Independent Review Decision**

**DATE OF REVIEW:** 9/8/2010

**IRO CASE #:**

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

The item in dispute is the prospective medical necessity of 12 additional sessions of physical therapy for the right shoulder.

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

The reviewer is a licensed Physical Therapist. This reviewer has been practicing for greater than 10 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 agrees with the previous adverse determination regarding the prospective medical necessity of 12 additional sessions of physical therapy for the right shoulder.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
, and, MD

These records consist of the following (duplicate records are only listed from one source):

Records reviewed from: Consent to Treat – 9/2/09; Patient Medical History – 9/2/09, Script – 8/9/09 & 11/3/09(x2), Exercise Log – 9/2/09-7/28/10; NDPTA Peer Review Report – 9/4/09-9/14/09; Workforce Safety & Insurance report – 9/8/09, UR Review Request – 9/3/09; Notes – 9/2/09-7/28/10, Pre- auth Request – 5/18/10 & 7/28/10, Progress Note – 7/6/10, General Eval Report – 6/18/10, Upper Extremity Eval – 8/18/10; Shoulder Eval – 9/2/09; Discharge Note – 8/27/09, Progress note – 8/16/09, Exercise Logs – 8/3/09-8/27/09, Daily Treatment Notes – 8/24/09-8/27/09;, PT letter – 10/1/09; Utilization Review Log – 4/30/09-7/28/10; Denial Letter – 8/3/10; and, MD PT Prescription – 3/1/10 & 7/28/10.

Records reviewed from: Denial Letter – 8/2/10 & 8/20/10;, MD MMI Letter – 4/1/10, NCS/EMG report – 3/30/09 & 11/10/09, Referral Request – undated, Office Notes – 3/17/09-12/3/09; Pre-auth Request – 3/22/10; Sportherapy Eval – 3/22/10;, MD report – 2/25/10;, MD Office Note – 10/3/05;, DO Re-eval report – 1/7/10;, DO MRI report – 4/1/09;

Office Note – 4/17/09; MD report – 5/5/09-5/26/09, Procedure Report – 5/21/09; MD CT & Cervical Myelogram reports – 5/21/09; and PA-C SOAP note – 6/16/09-8/20/09.

Records reviewed from, MD: Office Notes – 12/14/09-7/1/10 and, MD MRI report – 7/22/10.

A copy of the ODG was not provided by the Carrier/URA for this review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient is a male who injured his right shoulder on xx/xx/xx when a drilling rig component hit his right shoulder. He sustained a right axillary nerve palsy documented by an EMG and NCV on 3/30/09.

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

Upon review of the clinical information provided and the ODG guidelines, the patient has completed approximately 36 physical therapy sessions since August 2008. He is now x years post injury. Review of the documentation of the progress notes for his last three weeks of therapy provided at indicated on most visits that the patient had 'no new complaints' and indicated good tolerance of rehabilitation. Exercise flow-sheet review indicates he was performing 45-50 minutes of shoulder conditioning/stabilization and strengthening in addition to receiving moist heat. At this point, the patient should be independent with his strengthening/stabilization program. The records indicate that the patient has returned to playing golf and is also working out at a fitness center.

The closest category that this injury would fall under when reviewing the ODG for the shoulder is: Brachial Plexus Lesions (Thoracic Outlet Syndrome) ICD9: 353.0 which allows 14 visits over 6 weeks. However, one must take into consideration that the axillary nerve injury sustained in this case is different than TOS. The 36 sessions approved appears sufficient to get the patient to a point where he can safely progress to an independent home exercise program.

According to the ODG; Physical Therapy is ... 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. *Impingement syndrome*: For impingement syndrome significant results were found in pain reduction and isodynamic strength. 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. 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.

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. External rotator cuff strengthening is recommended because an imbalance between the relatively overstrengthened internal rotators and relatively weakened external rotators could cause damage to the shoulder and elbow, resulting in injury.

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. 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. 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.

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

**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)