

Notice of Independent Review Decision

DATE OF REVIEW: 03/29/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy

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

This case was reviewed by a Texas licensed DO, specializing in Orthopedic Surgery. The physician advisor has the following additional qualifications, if applicable:

AOA Orthopaedic Surgery

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Physical Therapy	97010, 97014, 97032, 97035, 97110, 97140	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		17	03/11/2011	03/11/2011
2	Claim File		1	03/14/2011	03/14/2011
3	Office Visit Report		29	10/19/2010	10/19/2010
4	IRO Request		9	03/04/2011	03/11/2011
5	Op Report		3	10/17/2010	10/17/2010
6	Office Visit Report		2	10/10/2010	10/10/2010
7	PT Notes		41	01/03/2011	01/28/2011
8	Initial Request		1	01/28/2011	01/28/2011
9	Initial Denial Letter		6	02/02/2011	02/07/2011
10	Initial Denial Letter		6	02/02/2011	02/07/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a XX-year-old male whose date of injury is XX/XX/XX. The mechanism of injury is described as electrocution. The diagnosis is shoulder pain. An undated x-rays revealed good healing of the fractured sites (no radiologist's analysis provided). Physical examination on 1/27/11 reported ROM passively to 110 degrees, actively to 90 degrees, limited internal rotation, rotator cuff is still 3/5, and neurovascularly intact otherwise. Treatments to date include an unspecified 10/10 surgery, 10/17/10 intramedullary rodding of the left proximal humerus, open reduction of the left shoulder dislocation, and open rotator cuff repair, medication (Darvocet), 23 PT visits as per 1/28/11 note, and 12 home health PT visits. 18 sessions of Physical therapy to include CPT codes 97010, 97014, 97032, 97035, 97110 and 97140 was recommended and requested for dates of service 1/25/11 to 3/8/11. On 2/2/11, Dr. reviewed the request and denied for lack of objective documentation of progress in PT prior to the request. An appeal request was reviewed on 2/7/11 by Dr.. Dr. again denied the requested services and indicated that the patient had exceeded the Official Disability Guidelines and documented that progress notes continued to indicate no change in the patient's condition. A request for independent review was submitted on 3/4/11.

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

The request for independent review for additional physical therapy visits for the left shoulder is upheld as not medically necessary. The patient has already received at least 35 PT sessions (23 PT sessions as per 1/28/11 note, and 12 home health PT visits). Exceptional factors are required to justify continued sessions beyond the recommended number. If indeed the patient is not yet fully improved, factors of prolonged or delayed recovery should be identified and addressed rather than pursuing a continued therapy that provides no complete benefit. Furthermore, maximized pharmacotherapy was not validated with pain and symptom logs with medication use. This is especially pertinent as the most recent office visit note dated 1/27/11 did not report

use of medication for pain management, which may impact therapy sessions. At this point in time, the medical necessity of this request is not established. IRO recommends upholding prior decisions.

Official Disability Guidelines Treatment in Workers' Compensation, Online Edition

Chapter: Shoulder

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.

ODG Preface

There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.

Physical therapy

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-surgical treatment, arthroscopic: 24 visits over 14 weeks

Post-surgical treatment, open: 30 visits over 18 weeks

Dislocation of shoulder (ICD9 831):

Medical treatment: 12 visits over 12 weeks

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

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with 28 TAC §12.206(d)(19), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 03/24/2011.