



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 12-27-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Extension (12 Sessions) - Occupational Therapy, right shoulder (postop)

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

Board Certified in Occupational Medicine and American Board of Preventive Medicine

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 8-16-10 Surgery performed by Dr..
- 9-9-10 MD., referral for physical therapy to the right shoulder 3 x 4.
- 9-15-10 Physical therapy evaluation.
- 10-12-10 MD., referral for physical therapy to the right shoulder 3 x 4.
- 10-13-10 physical therapy re evaluation.
- 11-17-10 MD., performed a Utilization Review.
- 11-12-10 Physical therapy re-evaluation.
- 11-23-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

8-16-10 Surgery performed by Dr.: right arthroscopic glenohumeral debridement, extensive. Arthroscopic rotator cuff repair through a separate incision. Open biceps tenodesis.

9-9-10 MD., referral for physical therapy to the right shoulder 3 x 4. Diagnosis: partial supraspinatus full thickness subscapular tear.

9-15-10 Physical therapy evaluation.

10-12-10, MD., referral for physical therapy to the right shoulder 3 x 4.

10-13-10 physical therapy re evaluation.

11-17-10 MD., performed a Utilization Review. The date of injury is xx/xx/xx(almost 5 months ago). is a xx with right shoulder pain. The patient underwent right shoulder arthroscopy with rotator cuff repair and open biceps tenodesis on 08/16/10. Requested were 12 postoperative sessions of therapy. The patient has attended 24 postoperative sessions of therapy to date. Range of motion and strength were poor on 11/12/10. There was no complete set of physical therapy notes submitted, by which plateauing and progress might be assessed. There are no objective indications of progressive, clinically significant improvement from prior therapy. Continuation of therapy should be

predicated on a formal assessment validating improvement in function at Intervals of 6 sessions. There is no indication as to why supervised therapy is required for this patient. At this point in time, the patient should be proficient in a home exercise program. The medical necessity of this request is unsupported by the records. This conclusion is consistent with Official Disability Guidelines (preface and chapter on the shoulder).

11-12-10 Physical therapy re-evaluation.

11-23-10 MD., performed a Utilization Review. The evaluator reported the claimant has had 24 visits postop physical therapy. No MD clinical notes provided to indicate why the claimant slow to progress or if there is underlying secondary gait etiology. There was an improvement in range of motion over the past month. The claimant should be able to complete further strengthening and range of motion exercises at home.

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

Ms. was injured on xx/xx/xx and underwent right shoulder arthroscopic RCR with biceps tenodesis and an extensive glenohumeral debridement on 8/15/10. This was followed with 24 OP OT sessions. PT evaluation on 10/13/10 noted AROM/PROM abd/add was not tested, ext/flex 35/65, IR/ER 0, elbow 0/140, sup/pro 80/90. OT evaluation on 11/12/10 noted shoulder AROM/PROM abd/add 65 degrees, ext/flex 23/90, IR/ER 10/15 and MMT 3 to 4/5 depending upon muscle tested. The request is for additional OT consisting of therapeutic exercise, manual therapy and ultrasound.

As there has been documented improvements with the OT even though slow, which could be a result of the extensive debridement at the time of the surgery and as the ODG guidelines are just that, thus if necessary they can be exceeded. In this case with the continued significant loss in ROM, most likely more than could be addressed with a HEP as she is performing, additional OT 2x3 consisting of therapeutic exercise and manual therapy for no more than four units per sessions would be medically reasonable to determine if additional will be of benefit.

ODG-TWC, last update 12-15-10 Occupational Disorders of the Shoulder – 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-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

These guidelines provide evidence-based benchmarks for the number of visits with a physical or occupational therapist and the period of time during which these visits take place. (Note: These guidelines do not include work hardening programs.) The physical therapy guidelines do not describe the type of therapy required, and the number of visits does not include physical therapy that the patient should perform in their own home or work site, after proper training from a clinician. Unless noted otherwise, the visits indicated are for outpatient physical therapy, and the physical therapist's judgment is always a consideration in the determination of the appropriate frequency and duration of treatment. Support for the physical therapy guidelines is relevant medical literature and actual experience data, combined with consensus review by experts. The most important data sources are the high quality medical studies that are referenced in the treatment guidelines, ODG Treatment in Workers' Comp, within the Procedure Summaries of each relevant chapter, summarized under the entry for "Physical Therapy." For clinical trials that show effectiveness for these therapies, the number of visits required to achieve this are isolated from each study and combined with the same information from other successful studies to arrive at the benchmark number of visits in ODG.

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.

Generally there should be no more than 4 modalities/procedural units in total per visit, allowing the PT visit to focus on those treatments where there is evidence of functional improvement, and limiting the total length of each PT visit to 45-60 minutes unless additional circumstances exist requiring extended length of treatment. Treatment times per session may vary based upon the patient's medical presentation but typically may be 45-60 minutes in order to provide full, optimal care to the patient. Additional time may be required for the more complex and slow to respond patients. While an average of 3 or 4 modalities/ procedural units per visit reflect the typical number of units, this is not intended to limit or cap the number of units that are medically necessary for a particular patient, for example, in unusual cases where co-morbidities involve completely separate body domains, but documentation should support an average greater than 4 units per visit. These additional units should be reviewed for medical necessity, and authorized if determined to be medically appropriate for the individual injured worker.

As described above, for more detail users should refer to ODG Treatment in Workers' Comp, within the Procedure Summaries of each relevant chapter, for recommendations about specific treatments and modalities, along with supporting links to the highest quality relevant medical studies, which have been summarized, rated, and highlighted. In these Procedure Summaries ODG covers many different types of treatments that can be supported by the medical evidence, and it also identifies the maximum number of visits that can be justified by the evidence; however, this does not mean that a provider should do every possible treatment that may be recommended (actually, this would be highly unlikely since different specialties would be required), or always deliver the maximum number of visits, without taking into account what was needed to cure the patient in a particular case. Furthermore, duplication of services is not considered medically necessary. While the recommendations for number of visits are guidelines and are not meant to be absolute caps for every case, they are also not meant to be a minimum requirement on each case (i.e., they are not an "entitlement"). Any provider doing this is not using the guidelines correctly, and provider profiling would flag these providers as outliers. This applies to all types of treatment, and not just physical therapy. Furthermore, flexibility is especially important in the time frame recommendations. 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. When there are co-morbidities, the same principles should apply as in the ODG guidelines for return-to-work. See Additional note on co-morbidities at the end of the description of the Return-To-Work "Best Practice" Guidelines. In estimating the maximum number of treatment visits for workers with multiple diagnoses, users should use the number from the diagnosis with the longest number of visits. This assumes that whatever separate therapy, if any, that the lesser diagnosis requires, it can be done during the same visits addressing the more serious problem. If there are reasons why these therapies cannot be concurrent, documentation should support medical necessity. For example, in unusual cases where co-morbidities involve completely separate body domains, requiring separate treatments that would be difficult to combine, either additional visits or additional time for a visit may be justified. [For the purpose of this discussion, we would assume there could be only three separate body domains: (1) spine and pelvis; (2) upper extremity and hands; & (3) lower extremity and feet.] Of course, each billed treatment should require one-on-one patient contact with the licensed therapist and not include modalities/exercises that the patient has learned to do on their own without supervision, and there should also be some economies of scale such that the involvement of two body domains should not require either a doubling of the number of visits or a doubling of the modalities (or time) per visit. Also see Multiple incidences of disability duration in the same section for recommendations regarding number of treatment visits, for example, physical therapy, in these situations. And physical therapy visits post surgery should be considered separately from visits used up in an attempt at conservative treatment that might have avoided surgery.

Physical medicine treatment (including PT, OT and chiropractic care) should be an option when there is evidence of a musculoskeletal or neurologic condition that is

associated with functional limitations; the functional limitations are likely to respond to skilled physical medicine treatment (e.g., fusion of an ankle would result in loss of ROM but this loss would not respond to PT, though there may be PT needs for gait training, etc.); care is active and includes a home exercise program; & the patient is compliant with care and makes significant functional gains with treatment.

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)**