



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 6/23/2011

**IRO CASE #:**

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

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

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The 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 physical therapy, 12 sessions, right shoulder.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:  
Provider and Clinic

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Clinic: Office Notes – 6/18/10-6/7/11, Re-evaluation notes – 8/19/10-5/18/11, PT Notes – 8/5/10-5/13/11, Initial Evaluations – 7/21/10 & 11/18/10; Hospital Operative Report – 11/4/10; and MD MRI Arthrogram report – 6/28/10.

Records reviewed from Provider were all duplicates from Clinic.

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

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This gentleman was injured at work on XX/XX/XXXX. There is no in-depth description in available medical records of this individual's injury, but apparently, the injury was to the shoulder on the right side. The initial treatment of the injury is not identified in the medical record, but on XX/XX/XXXX M.D. saw the patient in orthopedic

consultation. Dr. noted pain and weakness in the shoulder. He described good passive range of motion, tenderness over the rotator cuff, and weakness in flexion and abduction. X-rays were said to show moderate degenerative changes of the acromioclavicular joint. A diagnosis of rotator cuff syndrome and sprain of the rotator cuff was made. Dr. recommended an MRI arthrogram of the shoulder.

An MRI arthrogram of the shoulder was performed on June 28, 2010. This showed minimal subacromial and sub deltoid bursitis, impingement, tendinitis and tendinosis of the long head of the biceps and subscapularis tendons, and no evidence of full thickness cuff tear.

On July 13, 2010, Dr. injected the right shoulder subacromial space. The injured worker began a physical therapy program on July 21, 2010. He received 13 physical therapy visits between August 5, 2010 and September 20, 2010. On August 25, Dr. re-evaluated the individual and recommended that therapy be continued. On September 21, Dr. saw the individual and stated that he was still having pain and weakness and recommended a diagnostic arthroscopy.

On November 4, 2010, Dr. performed a right shoulder diagnostic arthroscopy, revision of right shoulder arthroscopic rotator cuff repair, and primary open right shoulder biceps tenodesis. Dr. found a small, full-thickness tear of the supraspinatus and a partial tear of the biceps tendon.

On November 19, the injured worker began a physical therapy program. The physical therapy evaluation on that date indicated that the patient had Parkinson's disease. The injured worker had 36 postoperative physical therapy visits, according to the available medical records, between November 18, 2010 and May 18, 2011. There are various descriptions of range of motion measurements and weakness. Beginning on February 23, 2011, strength in the shoulder was recorded as 4-/5. The injured worker had 150° of flexion and 155° of abduction at that time. On his last evaluation dated May 18, 2011, active range of motion described was 180° of flexion and abduction and 60° of internal and external rotation. Strength remained at 4-/5.

On June 7, 2011, Dr. stated that the injured worker had Parkinson's disease and "it has taken him a lot 'lower' time to recover his strength and useful function." He recommended continuation of physical therapy in spite of ODG Guidelines, opining that Parkinson's disease had delayed progress.

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

According to available records, this worker injured his shoulder on XX/XX/XXXX. He was found to have partial rotator cuff tear, tendinitis, tendinosis, bursitis, and impingement. He had 13 physical therapy visits, but failed to make adequate progress. On November 4, he underwent surgery for rotator cuff repair and primary right shoulder biceps tenodesis. Following surgery, he had a total of 36 physical therapy sessions, according to available medical records. Various degrees of progress were described, but in the last physical therapy evaluation, the injured worker had achieved 180° of flexion and abduction actively and 60° of internal and external rotation actively.

*AMA Guides to the Evaluation of Permanent Impairment* indicate that 180° of flexion and abduction are normal and do not yield impairment. Sixty degrees of external rotation also yields no impairment. Sixty degrees of internal rotation yields minimal impairment, 2%. After 21 physical therapy sessions between February 23, 2011 and May 18, 2011, strength was unchanged at 4-/5.

ODG Guidelines recommend 30 physical therapy treatments over a period of 18 weeks for post-surgical treatment of rotator cuff syndrome and impingement syndrome. This injured worker has received six sessions over and above the recommended treatment in the postoperative period. Strength has been unchanged for 3 months, and he has reached normal range of motion except for slight limitation of internal rotation. Since the ODG Guidelines recommend 30 visits over 18 weeks and this individual has already exceed that treatment recommendation, it is unlikely that additional therapy will provide additional benefit to that which would be expected with a home exercise program. Records do confirm that he has Parkinson's disease, but his progress has plateaued. He has already exceeded the guidelines; therefore the requested treatment is not medically necessary.

**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 KNOWLEDGBASE
- 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)