



DATE OF REVIEW: March 22, 2011

IRO Case #:

Description of the services in dispute:

8 occupational/physical therapy visits.

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 extensive experience with femoral and acetabular surgery. 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 8 occupational/physical therapy visits are not medically necessary.

Information provided to the IRO for review:

Patient clinical history [summary]:

The patient is a xxx who suffered an injury to his left shoulder lifting a box to a pallet on xx/xx/xx. On 10/21/10, he underwent arthroscopic rotator cuff repair, subacromial decompression, and distal clavicle resection. He continues to complain of pain with overhead activity. He has completed 24 sessions of physical therapy, and the current request is for an additional 8 sessions of OT/PT. This request has been considered and denied. It was appealed and denied.

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

The prior denials of this request for 8 additional sessions of physical/occupational therapy were appropriate and should be upheld. The criteria published in the ODG 2011 preface and shoulder chapter are cited below. The appropriate regimen of physical therapy after arthroscopic rotator cuff repair, subacromial decompression and distal clavicle resection has been provided. The 24

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sessions of supervised physical therapy should be followed by a home program of exercises. No clear indication for supervised physical therapy has been provided. The prior denials are upheld. There is no clear indication to exceed the recommendations published in the ODG 2011 shoulder chapter cited below. The current request for additional physical therapy/occupational therapy exceeds current guidelines published in ODG 2011.

The patient's primary complaint at this time is pain. Painful symptoms after arthroscopic surgery can be dealt with medically utilizing pain medication and local anesthetic/cortisone injections. Supervised physical therapy is best justified for improvement in range of motion and strength. The patient should be transitioned into an unsupervised home exercise program during and after supervised physical therapy. This patient should be reevaluated after a reasonable period of unsupervised physical therapy.

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

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

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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

## Physical Therapy Guidelines

Physical Therapy Guidelines, showing recommended frequency and duration of PT visits are next. Only appropriate conditions have physical therapy guidelines. 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

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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

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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.

ODG, 2011, preface and shoulder chapter passages cited above.