

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

DATE OF REVIEW: February 16, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 2-3xWk x4-6Wks 97010 97110 97530 97140 G0283-PRN

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

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:

Records were received from Insurance Company and and only included the following:

01-11-11: Claim File Analysis by RN
06-13-11: Outpatient note by MD
06-17-11: Initial Plan of Care from physical therapy
06-20-11: UR approving 9 sessions of PT
06-21-11, 06-23-11, 06-24-11, 06-27-11, 06-29-11, 06-30-11, 07-05-11, 07-06-11,
07-08-11: Physical Therapy Notes from
09-12-11: Office visit at Sports & Spine Institute with DO
12-05-11: Physical Therapy Evaluation by
01-05-12: Initial Plan of Care from physical therapy
01-09-12, 01-12-12, 01-03-12, 01-05-12, 01-16-12, 01-17-12, 01-19-12, 01-24-12, 01-
26-12, 01-27-12: Physical Therapy Notes
01-10-12: UR performed by MD
01-19-12: UR performed by MD

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records received, the claimant is a female who on xx/xx/xx received multiple injuries after falling while “trying to close the door of semi-truck”. The carrier has accepted contusion to the left hand with laceration/abrasion of the right & middle fingers; bilateral shoulder strain; right knee strain; lumbar strain; and coccydynia as the only compensable injuries. As of recently, according to information provided in the UR reports, not by actual medical records, the claimant had a MRI of the right shoulder following an arthrogram on 10-26-11. Findings were consistent with tendonitis in the supraspinatus and infraspinatus tendons. There appeared to be a small calcification distally in the infraspinatus tendon due to calcific tendonitis. A 4 mm focus of gadolinium was also seen distally in the infraspinatus tendon due to a small partial thickness undersurface tear. No full thickness rotator cuff tears were identified. On 11-01-11, the claimant was seen in clinic for right shoulder and right knee pain. The right shoulder was tender over the AC joint and acromial margins.

01-11-11: Claim File Analysis by RN. According to the Analysis on 08-20-08 a MRI of the left shoulder showed “degenerative changes glenohumeral joint. Findings compatible with rotator cuff tear.” A MRI of the lumbar spine showed “Mild disc protrusions, slightly flattening the thecal sac at the lower three levels. Mild degenerative facets L5-S1 and L4-5.” On 03-03-09 MRI of the right shoulder showed “Findings consistent with tendinitis in the supraspinatus and infraspinatus tendons. No rotator cuff tear is seen.” On 03-17-10 MRI of the lumbar spine showed “Mild straightening of the lumbosacral spine with loss of the lordotic alignment. Mild broad disc bulge at multiple levels with no significant central canal stenosis, no neural foraminal stenosis. Mild degenerative articular facets.” On 10-14-08 the claimant underwent arthroscopic repair of rotator cuff tear of the left shoulder, with subacromial decompression, distal clavicle excision, and biceps tenotomy.

06-13-11: Outpatient note by MD. Diagnosis: Right SI pain and dysfunction and L5-S1 disc disease. Recommendations: 6 sessions of physical therapy for the SI problem.

09-12-11: Office visit at Sports & Spine Institute with DO. Physical examination was unchanged from a previous January 2011 examination. There were reports of pain to palpation on fairly light touch over the lumbosacral region and exquisite tenderness to palpation of the superior aspect to the right SI joint with no pain on the left. The neurologic examination of the lower extremities was normal with intact reflex at patella and Achilles in the left and right. Sensory examination was normal. Positive straight leg raising, positive neural tension sign on the right with pain reported into the right calf and top of the right foot. The right upper extremity examination noted global tenderness of the glenohumeral region with restricted motion at 95 degrees of flexion, 80 degrees of abduction, and 60 degrees of extension. Adduction was normal at 45 degrees and internal rotation was finger tip to L5. There was 4+ weakness with increase of subjective pain complaints on resisted abduction, anterior flexion, Belly Press, and Lift-Off maneuver cause some anterior shoulder pain.

12-05-11: Physical Therapy Evaluation by. Plan/Recommendation: PT to increase ROM to full and increase strength for functional use of right shoulder. Frequency 2 x week for 6 weeks: 12 sessions.

01-09-12, 01-12-12, 01-03-12, 01-05-12, 01-16-12, 01-17-12, 01-19-12, 01-24-12, 01-26-12, 01-27-12: Physical Therapy Notes from. On the assessment of the notes for the time period of 01-16-12 through 01-19-12 it was noted that she was progressing toward goals but was lacking ROM and strength. On the assessment of the notes for the time period of 1-24-12 through 1-27-12 it was noted that she incurred a fall increasing her pain and that no progress was made that week.

01-10-12: UR performed by, MD. Reason for Denial: The request is for medical necessity for physical therapy 2 times a week x 6 weeks to the right shoulder and lumbar spine. Medical records demonstrate this patient has had 9 sessions of PT for the lumbar spine, 12 session of PT for the shoulder status post arthroscopy. Current guidelines indicate that 10 visits over 8 weeks for the lumbar spine is considered reasonable and necessary, and 24 visits over 14 weeks is considered reasonable for the shoulder. As this patient has already had 9 sessions of PT for the lumbar spine, the request additional request for 2 times 6 weeks would exceed the recommended allowable for the lumbar spine. This patient has already had 12 sessions of PT for the shoulder. The requested 2 times 6 weeks to the shoulder would be reasonable, as 24 visits over 14 weeks is considered reasonable for this problem. Based on the clinical information submitted for this review and using the evidence-based peer-reviewed guidelines referenced above, this request for Physical Therapy 2xWkx6Wks RT shoulder/Lumbar is non-certified.

01-19-12: UR performed by MD. Reason for Denial: As per report dated 1-3-12, the patient reports increased pain on exercise. Upon review of the report, there are no recent comprehensive physical examination findings of the provider submitted for

review. Moreover, there are no progress reports from the previous Physical Therapy sessions that objectively document the clinical and functional status of the patient to address the need for this request. 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, operative summary of the previous shoulder surgery was not submitted for review and verification. With this, the previous non-certification of the request is upheld.

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

Denial of Physical Therapy 2-3xWk x4-6Wks 97010 97110 97530 97140 G0283-PRN is upheld/agreed upon. There is lack of clinical information: 1) There is no notation as to the amount of, date of, or progress with any therapy after the original date of injury in xxxx. 2) There is no notation as to the type of or date of surgery or the amount of postop therapy to date. 3) Given original diagnoses of lumbar and shoulder strains, ODG Low Back and Shoulder chapters recommend 10 PT visits over 8 weeks. Therefore, this current request well exceeds ODG recommended number and time frame for basic PT for these diagnoses.

ODG:

ODG Physical Therapy Guidelines –

Allow for fading of treatment frequency (from up to 3 or more 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](#), including assessment after a "six-visit clinical trial".

Lumbar sprains and strains (ICD9 847.2):

10 visits over 8 weeks

Sprains and strains of unspecified parts of back (ICD9 847):

10 visits over 5 weeks

Sprains and strains of sacroiliac region (ICD9 846):

Medical treatment: 10 visits over 8 weeks

Lumbago; Backache, unspecified (ICD9 724.2; 724.5):

9 visits over 8 weeks

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

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)**