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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 05/11/12

**IRO CASE #:**

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

Physical therapy twice a week for four weeks for the right shoulder to include CPT codes 97110 and 97140

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

Board Certified in Orthopedic Surgery

### **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.

Physical therapy twice a week for four weeks for the right shoulder to include CPT codes 97110 and 97140 - Upheld

## **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On xxxxx, provided an adverse determination for physical therapy that had been requested three times a week for four weeks for the right shoulder. Dr. examined the patient on xxxxx. It was noted the patient had been laid off. He had undergone surgery on 11/01/11 to include a rotator cuff tear, biceps tenodesis, and a subacromial decompression. He could actively forward flex to 130 degrees and he could externally rotate to 50 degrees. He had good strength. Additional therapy two to three times a week for four weeks was recommended in regard to his rotator cuff repair. Mr. examined the patient in therapy on 03/19/12. He had tenderness in the anterior shoulder region. Flexion was 135 degrees, abduction was 115 degrees, and internal and external rotation were 60 degrees. His upper extremity strength was 4/5. Therapy was prescribed two to three times a week for four weeks and noted it would not exceed more than four total modalities for each visit. On 03/22/12, Dr. again recommended therapy twice a week for four weeks. The patient was reevaluated by Dr. on 03/26/12. He was feeling 75% better and had improved significantly. Forward flexion was 160 degrees and he could externally rotate to 30 degrees. He had mild weakness with abduction and external rotation. Continued therapy was recommended. On 03/27/12, M.D., on behalf of provided an adverse determination for the requested right shoulder physical therapy twice a week for four weeks for CPT codes 97110 and 97140. M.D., also on behalf of provided an adverse determination on 04/10/12 for the eight sessions of physical therapy for the right shoulder to include CPT codes 97110 and 97140. Dr. noted on 04/10/12 he had returned a phone call to Dr. regarding the medical necessity of the requested therapy. He noted another month of therapy had been requested due to the large rotator cuff tear and the residual limitations with range of motion and strengthening. He noted Dr. felt the patient was able to do a home exercise program and did not need additional therapy. Dr. addressed a Certificate of Medical Necessity on 04/16/12 for the requested physical therapy to the right shoulder. On 04/26/12, the patient was 85% better when he returned to Dr.. He did have some weakness, but he was improving and pleased with his result. Forward flexion was 160 degrees and external rotation was 30 degrees. He continued with mild weakness and biceps contour was normal. It was noted his therapy had been

denied and he was advised to continue his strengthening on his own. It was noted an FCE had been recommended.

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

It appears based on the documentation provided that he has improved, 85% according to the 04/26/12 note, and a return to work is being planned. The patient is being sent for an FCE as a final evaluation for return to work. It appears as though the patient has done quite well. Secondly, the patient has exhausted what would be considered reasonable and necessary and supported by the ODG as far as the number of physical therapy visits received over time. This patient has had over 30 physical therapy visits, which exceeds the ODG recommendations for post surgical therapy for the rotator cuff. Therefore, the requested physical therapy twice a week for four weeks for the right shoulder to include CPT codes 97110 and 97140 are neither reasonable nor necessary and the previous adverse determinations should be upheld at this time.

**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)**