ReviewTex. Inc.

1818 Mountjoy Drive
San Antonio, TX 78232
(phone) 210-598-9381 (fax) 210-598-9382
reviewtex@hotmail.com

Notice of Independent Review Decision

Date notice sent to all parties:

March 6, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

8-12 sessions of physical therapy (right shoulder) 2-3 x per week for 4 weeks

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

Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Cover sheet and working documents
Shoulder ultrasonography dated 10/04/12
Office note dated 10/04/12, 10/18/12, 11/01/12, 11/21/12, 01/24/13
Utilization review determination dated 01/31/13, 02/12/13
Rehabilitation evaluation dated 12/04/12
Psychological evaluation dated 12/05/12
Physical therapy evaluation dated 12/05/12
Pre-authorization summary form undated
Letter dated 12/17/12
Patient treatment goals and objectives dated 12/17/12
Program overview undated
Right shoulder MRI dated 01/02/13
Letter from patient dated 01/14/13
Functional capacity evaluation dated 11/09/12
MRI lumbar spine dated 10/23/12
Physical/occupational therapy order sheet dated 10/04/12, 01/24/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a 58 year old male whose date of injury is xxxxxx. On this date the patient rolled over his truck while at work. He went to the ER afterwards, but his shoulder did not really start hurting until a couple days later, per note dated xxxxx. Note dated 10/18/12 indicates that the patient saw ortho doctor who stated that he needs more PT due to a finding of inflammation in the right shoulder. Diagnoses are listed as sprain/strain of shoulder and upper arm; lumbar strain and adhesive capsulitis of the shoulder. Note dated 11/01/12 indicates that the patient has received NSAIDs, muscle relaxants and physical therapy. The patient's course has improved. Functional capacity evaluation dated 11/09/12 indicates that inappropriate horizontal strength change was reported on 2 of 3 monitored tests indicating inconsistent performance. Physical therapy evaluation dated 12/05/12 indicates that physical therapy x 10 sessions provided 60% improvement in low back and 40% improvement in right shoulder pain. Shoulder injection last month provided no pain relief. On physical examination right shoulder range of motion is flexion 143, abduction 118, rotation to L2. MRI of the right shoulder dated 01/02/13 revealed tendinosis and partial thickness, partial width fraying involving the supraspinatus and infraspinatus tendons without discrete full thickness tear; no muscle belly edema or fatty atrophy is seen. There are advanced osteoarthritic changes of the glenohumeral articulation with no alignment abnormality. There is extensive degenerative signal seen involving the anterior and posterior glenoid labrum seen predominantly along the inferior half of the bony glenoid. Report dated 01/24/13 notes current medications are Ambien, Glimepiride, Lisinopril, Metformin hydrochloride, Naproxen, Vicodin and Xanax. On physical examination of the right shoulder AROM is 130 degrees, 30 degrees, 80 degrees and L3. There

is no inferior, anterior or posterior instability. Neer's and Hawkins tests are mildly positive. Strength is rated as 4/5 supraspinatus, 4+/5 infraspinatus, 5/5 deltoids, 5-/5 biceps.

Initial request was non-certified on 01/31/13 noting that the patient has completed 10 physical therapy visits and was approved for 80 hours of CPMP, but reportedly could not attend for more than 4 hours. There is no documentation of the claimant's response and/or compliance with physical therapy in the past, and the claimant is 5 months status post injuries which per diagnoses on file, were mostly of a soft tissue nature. In the absence of physician contact to gain a better understanding of the clinical picture, the request for 8-12 physical therapy visits, right shoulder, 2-3 times a week cannot be recommended as medically necessary. The recommendation would be for transition to a home exercise program. The denial was upheld on appeal dated 02/12/13 noting that the guidelines allow for 10 visits over 8 weeks, in order to help the patient transition to a self-directed home exercise program as an extension of the treatment process. The patient has reportedly already completed 12 physical therapy sessions. As such, the patient has already exceeded the guideline recommendations for his condition. The records show that the patient was recently authorized for participation in a chronic pain management program. It was noted that physical therapy failed to resolve his symptoms.

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

Based on the clinical information provided, the request for 8-12 sessions of physical therapy (right shoulder) 2-3 x per week for 4 weeks is not recommended as medically necessary. The patient has completed at least 10 visits of physical therapy to date. The Official Disability Guidelines Shoulder Chapter supports up to 10 visits of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Additionally, the submitted records indicate that the patient has recently been authorized for a trial of chronic pain management program which denotes a finding that the patient has exhausted lower levels of care to include physical therapy. Given the current clinical data, the request for additional physical therapy is not indicated as medically necessary. The patient has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE

IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

ODG Knee and Leg Chapter

Physical medicine treatment	**Recommended. Positive limited evidence. As with any treatment, if there is no improvement after 2-3 weeks the protocol may be modified or re-evaluated. See also specific modalities. (Philadelphia, 2001) Acute muscle strains often benefit from daily treatment over a short period, whereas chronic injuries are usually addressed less frequently over an extended period. It is important for the physical therapy provider to document the patient's progress so that the physician can modify the care plan, if needed. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (eg, joint range-of-motion and weight-bearing limitations, and concurrent illnesses). (Rand, 2007) Controversy exists about the effectiveness of physical therapy after arthroscopic partial meniscectomy. (Goodwin, 2003) A randomised controlled trial of the effectiveness of water-based exercise concluded that group-based exercise in water over 1 year can produce significant reduction in pain and improvement in physical function in adults with lower limb arthritis, and may be a useful adjunct in the management of hip and/or knee arthritis. (Cochrane, 2005) Functional exercises after hospital discharge for total knee arthroplasty result in a small to moderate short-term, but not long-term, benefit. In the short term physical therapy interventions with exercises based on functional activities may be more effective after total knee arthroplasty than traditional exercise programs, which concentrate on isometric muscle exercises and exercises to increase range of motion in the joint. (Lowe, 2007) Supervised therapeutic exercise improves**

	outcomes in patients who have osteoarthritis or claudication of the knee. Compared with home exercise, supervised therapeutic exercise has been shown to improve walking speed and distance. (Rand, 2007) A physical therapy consultation focusing on appropriate exercises may benefit patients with OA, although this recommendation is largely based on expert opinion. The physical therapy visit may also include advice regarding assistive devices for ambulation. (Zhang, 2008) Accelerated perioperative care and rehabilitation intervention after hip and knee arthroplasty (including intense physical therapy and exercise) reduced mean hospital length of stay (LOS) from 8.8 days before implementation to 4.3 days after implementation. (Larsen, 2008) In patients with ACL injury willing to moderate activity level to avoid reinjury, initial treatment without ACL reconstruction should be considered. All ACL-injured patients need to begin knee-specialized physical therapy early (within a week) after the ACL injury to learn more about the injury, to lower the activity level while performing neuromuscular training to restore the functional stability, and as far as possible avoid further giving-way or re-injuries in the same or the other knee, irrespectively if ACL is reconstructed or not. (Neuman, 2008) Limited gains for most patients with knee OA. (Bennell, 2005) More likely benefit for combined manual physical therapy and supervised exercise for OA. (Deyle, 2000) Many patients do not require PT after partial meniscectomy. (Morrissey, 2006) There are short-term gains for PT after TKR. (Minns Lowe, 2007) Physical therapy and patient education may be underused as treatments for knee pain, compared to the routine prescription of palliative medication. (Mitchell, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) This study sought to clarify which type of postoperative rehabilitation program patients should undergo after ACL reconstruction surgery, comparing a

	neuromuscular exercise rehabilitation program with a more traditional strength-training regimen, and it showed comparable long-term primary and secondary outcomes between the 2 groups at 12 and 24 months. On the basis of the study, the authors recommend a combined approach of strength exercises with neuromuscular training in postoperative ACL rehabilitation programs. (Risberg, 2009) This RCT concluded that, after primary total knee arthroplasty, an outpatient physical therapy group achieved a greater range of knee motion than those without, but this was not statistically significant. (Mockford, 2008) Knee bracing after ACL reconstruction appears to be largely useless, according to a systematic review. The most important rehab for ACL surgery patients is to start physical therapy early and rigorously. Accelerated rehabilitation (starting at 3 weeks postoperatively rather than the traditional 3 months and intended to reduce the usual 6-month time for return to activity) was considered to be safe according to this review. The authors conclude that immediate postoperative weight-bearing, range of knee motion from 0° to 90° of flexion, and strengthening with closed-chain exercises are likely to be safe. They also suggest that starting eccentric quadriceps strengthening and isokinetic hamstring strengthening at week 3 after surgery may accelerate recovery. The reviewers found promising data for home-based rehabilitation for the motivated patient, but found doubtful support for neuromuscular training such as proprioceptive and balance training, perturbation training, and vibratory stimulation. (Kruse, 2012) See specific physical therapy modalities by name, as well as Exercise. See also Aerobic exercises; Activity restrictions; ACL injury rehabilitation; Aquatic therapy; Barefoot walking; Cold/heat packs; Compression garments; Computerized muscle testing; Continuous-flow cryotherapy; Continuous passive motion (CPM); Deep transverse friction massage (DTFM); Diathermy; Durable medical equipment (DME); Education; Electrical stimulators (E-stim); Electromyographic biofeedback treatment; Electrothermal shrinkage

	(for lax ACL); Flexionators (extensionators); Footwear, knee arthritis; Functional improvement measures; Functional restoration programs (FRPs); Gait training; Game Ready™ accelerated recovery system; Gym memberships; Heat; Home exercise kits; Immobilization; Interferential current stimulation (ICS); Iontophoresis; Joint active systems (JAS) splints; Joint mobilization; Kinesio tape (KT); Knee brace; Low level laser therapy (LLLT); Magnet therapy; Manipulation; Manual therapy; Massage therapy; Mechanical stretching devices (for contracture & joint stiffness); Non-surgical intervention for PFPS (patellofemoral pain syndrome); Orthoses; Phonophoresis; Power mobility devices (PMDs); Proprioception exercises; Pulsed magnetic field therapy (PMFT/PEMF); Static progressive stretch (SPS) therapy; Strapping; Strengthening exercises; Stretching and flexibility; Tai Chi; Taping; Therapeutic knee splint (patellofemoral pain); Traction, knee (skeletal traction treatment); Ultrasound, therapeutic; Walking aids (canes, crutches, braces, orthoses, & walkers); Work conditioning, work hardening. ***Active Treatment versus Passive Modalities*: See the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530).** **ODG Physical Medicine 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.** **Dislocation of knee; Tear of medial/lateral cartilage/meniscus of knee; Dislocation of patella (ICD9 836; 836.0; 836.1; 836.2; 836.3; 836.5):** **Medical treatment: 9 visits over 8 weeks** **Post-surgical (Meniscectomy): 12 visits over 12 weeks**

	Sprains and strains of knee and leg; Cruciate ligament of knee (ACL tear) (ICD9 844; 844.2): **Medical treatment: 12 visits over 8 weeks** **Post-surgical (ACL repair): 24 visits over 16 weeks** **Old bucket handle tear; Derangement of meniscus; Loose body in knee; Chondromalacia of patella; Tibialis tendonitis (ICD9 717.0; 717.5; 717.6; 717.7; 726.72):** **9 visits over 8 weeks** **Post-surgical: 12 visits over 12 weeks** **Pain in joint; Effusion of joint (ICD9 719.0; 719.4):** **9 visits over 8 weeks** **Arthritis (Arthropathy, unspecified) (ICD9 716.9):** **Medical treatment: 9 visits over 8 weeks** **Post-injection treatment: 1-2 visits over 1 week** **Post-surgical treatment, arthroplasty, knee: 24 visits over 10 weeks** **Abnormality of gait (ICD9 781.2):** **16-52 visits over 8-16 weeks (Depends on source of problem)** **Fracture of neck of femur (ICD9 820):** **Post-surgical: 18 visits over 8 weeks** **Fracture of other and unspecified parts of femur (ICD9 821):** **Post-surgical: 30 visits over 12 weeks** **Fracture of patella (ICD9 822):** **Medical treatment: 10 visits over 8 weeks** **Post-surgical (closed): 10 visits over 8 weeks** **Post-surgical treatment (ORIF): 30 visits over 12 weeks** **Fracture of tibia and fibula (ICD9 823)** **Medical treatment: 30 visits over 12 weeks** **Post-surgical treatment (ORIF): 30 visits over 12 weeks** **Amputation of leg (ICD9 897):** **Post-replantation surgery: 48 visits over 26 weeks** **Quadriceps tendon rupture (ICD9 727.65)** **Post-surgical treatment: 34 visits over 16 weeks** **Patellar tendon rupture (ICD9 727.66)** **Post-surgical treatment: 34 visits over 16 weeks** **Work conditioning** **See Work conditioning, work hardening**