

Notice of Independent Review Decision

October 28, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

10 Sessions of Physical Therapy

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

The physician performing this review is Board Certified, American Board of Physical Medicine & Rehabilitation. The physician is certified in pain management. The physician has a private practice of Physical Medicine & Rehabilitation, Electro Diagnostic Medicine & Pain Management in Texas. The physician is a member of the Texas Medical Association and the Houston Physical Medicine and Rehabilitation Society. The physician is licensed in Texas and Michigan and has been in practice for over 25 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)

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

Upon independent review, the physician finds that the previous adverse determination should be ~ Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

This is a worker who reportedly injured the right shoulder with repetitive lifting. She was initially diagnosed with a strain, but subsequently had a rotator cuff repair on 3/20/14. The post operative management is not clear. There is restricted motion and a request was submitted for 10 therapy sessions. I understand the

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insurance company challenged the injury as being work related. I do not see the results of this.

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

The request is more for adhesive capsulitis/frozen shoulder than for the shoulder repair. In short, there may be a role for the therapy, but not enough information was provided to see if there was prior therapy after surgery. The ODG allows 10 therapy sessions for nonoperative treatment, but she had surgery. Up to 40 sessions would be appropriate after surgery, but this would be over 16-19 weeks post surgery. She is now 31 weeks post surgery. The treatment time frame has been exceeded. The ODG allows therapy for a frozen shoulder (16 sessions), but requires it to be coordinated with a steroid injection

From the ODG:

Rotator cuff: There is poor data from non-controlled open studies favoring conservative interventions for rotator cuff tears, but this still needs to be proved. Considering these interventions are less invasive and less expensive than the surgical approach, they could be the first choice for the rotator cuff tears, until we have better and more reliable results from clinical trials. ([Ejnisman-Cochrane, 2004](#)) External rotator cuff strengthening is recommended because an imbalance between the relatively overstrengthened internal rotators and relatively weakened external rotators could cause damage to the shoulder and elbow, resulting in injury. ([Byram, 2009](#))

Adhesive capsulitis: For adhesive capsulitis, injection of corticosteroid combined with a simple home exercise program is effective in improving shoulder pain and disability in patients. Adding supervised physical therapy provides faster improvement in shoulder range of motion. When used alone, **supervised physical therapy is of limited efficacy in the management of adhesive capsulitis.** ([Carette, 2003](#)) Physical therapy following arthrographic joint distension for adhesive capsulitis provided no additional benefits in terms of pain, function, or quality of life but resulted in sustained greater active range of shoulder movement and participant-perceived improvement up to 6 months. ([Buchbinder, 2007](#)) Use of the Shoulder Dynasplint System (Dynasplint Systems, Inc., Severna Park, MD) may be an effective adjunct "home therapy" for adhesive capsulitis, combined with PT. ([Gaspar, 2009](#)) The latest UK Health Technology Assessment on management of frozen shoulder concludes that based on the best available evidence there may be benefit from stretching and from high-grade mobilization technique. ([Maund, 2012](#))

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-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):

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Medical treatment: 16 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

In short, there may be a role for the therapy, but not enough information was provided to see if there was prior therapy after surgery. The ODG allows 10 therapy sessions for nonoperative treatment, but she had surgery. Up to 40 sessions would be appropriate after surgery, but this would be over 16-19 weeks post surgery. She is now 31 weeks post surgery. The treatment time frame has been exceeded. The ODG allows therapy for a frozen shoulder (16 sessions), but requires it to be coordinated with a steroid injection

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)