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Notice of Independent Review Decision

Date: June 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient physical therapy twelve (12) sessions (3 times 4) to the left shoulder consisting of electrical stimulation, ultrasound, therapeutic exercises, therapeutic activities, and manual therapy not to exceed four (4) units per session

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Fellow of the American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

☒Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

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- Office visits (09/15/09 – 05/07/12)
- Diagnostics (09/28/09 – 12/06/11)
- Therapy (10/05/09 – 04/26/12)
- Reviews (12/09/09 – 08/04/11)
- Surgery (02/23/10 – 01/24/12)
- Utilization reviews (05/01/12 – 05/15/12)

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- Office visits (04/04/12 – 05/07/12)
- Utilization reviews (05/01/12 – 05/15/12)

TDI:

- Utilization reviews (05/01/12 – 05/15/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who injured her left shoulder when she slipped on wet floor on xx/xx/xx.

2009: On September 15, 2009, the patient was evaluated at emergency department (ED) for left arm and shoulder pain. The evaluator diagnosed left arm pain and musculoskeletal pain and prescribed naproxen and Vicodin.

M.D., an orthopedic surgeon, evaluated the patient for left arm and shoulder pain and stiff range of motion (ROM). X-rays of the left humerus were unremarkable. Dr. diagnosed probable frozen left shoulder and adhesive capsulitis and recommended conservative treatment with Lodine and physical therapy (PT).

The patient underwent electromyography/nerve conduction velocity (EMG/NCV) study of the upper extremities for chronic left shoulder pain and paresthesias. The report is incomplete.

From October through November, the patient attended 17 sessions of PT consisting of therapeutic exercises, therapeutic activities, ice and hot packs.

In December, M.D., performed a peer review and rendered the following opinions: (1) The extent of injury was left shoulder only. (2) There was no indication for other mitigating factors. (3) A consideration should have been given to manipulation under anesthesia (MUA). (4) Continued use of Lodine was reasonable.

On follow-up, the patient complained of constant pain to the upper arm with bruising that was ten days old. Examination revealed positive impingement and empty can signs, tenderness anteriorly on the biceps tendon, positive Yergason's and Speed's tests and small bruise on the anterior aspect of the biceps muscle. Dr. diagnosed left frozen shoulder versus possible rotator cuff tear and obtained magnetic resonance imaging (MRI) of the left shoulder that revealed changes of tendinosis of the supraspinatus, infraspinatus and the long head of the biceps, significant partial-thickness rotator cuff tear at the insertion of the infraspinatus tendon and subacromial/subdeltoid bursitis and subscapularis bursitis.

2010: In January 2010, Dr. administered a left subacromial space injection. The injection helped for one week.

On February 23, 2010, Dr. performed left shoulder arthroscopy, arthroscopic subacromial decompression and arthroscopic rotator cuff repair. From February through April, the patient attended 24 sessions of postop PT consisting of manual therapy, ice, hot pack and therapeutic activities.

On follow-up, Dr. noted that history was positive for asthma and sarcoidosis. The patient reported improvement with therapy. Dr. recommended continuing therapy.

In a functional capacity evaluation (FCE) dated May 17, 2010, it was noted that the patient's job required a sedentary physical demand level (PDL) with multiple overhead reaching activities and light lifting. The evaluator recommended a work conditioning program (WCP) to address areas of weakness and providing pertinent educational classes.

In June, the patient attended 10 sessions of WCP. Dr. maintained her on Darvocet N 100. In July, Dr. noted that the additional WCP was denied and referred the patient for IR evaluation.

On July 30, 2010, M.D., performed maximum medical improvement/impairment rating (MMI/IR) evaluation and assessed MMI as of August 9, 2010, with 12% whole person impairment (WPI) rating.

M.D., evaluated the patient for pins and needles sensation in the lateral shoulder with stabbing pain and intermittent radiation from the shoulder into the lateral elbow. Examination of the cervical spine revealed limited ROM, tenderness along the cervical paraspinals, trigger points in the paraspinals at C3-C6, bilateral upper trapezius and bilateral rhomboids and palpable taut band with impressive spot tenderness upon palpation of nodule with reproduction of pain. Dr. diagnosed chronic left shoulder pain, ordered an MRI and gave a trial of Cymbalta.

M.D., performed a designated doctor examination (DDE) and opined that the patient was not at MMI as further material recovery from or lasting improvement to her injury was anticipated.

In October, Dr. obtained EMG/NCV of the upper extremities that was unremarkable. Repeat EMG/NCV of the upper extremities obtained by M.D. was unremarkable for cervical radiculopathy and/or peripheral entrapment syndromes.

MRI arthrogram of the left shoulder revealed full-thickness tear of the distal supraspinatus tendon beginning 5 mm proximal to its insertion on the humerus and extending medially over an 11-mm distance with fluid signal intensity extending through this region into the subacromial-subdeltoid bursa consistent with full-thickness tear. There was a curved type II acromion with normal slope.

From October through November, Dr. maintained the patient on Lodine, Tylenol, Norco, Lidoderm patch and Cymbalta.

In December, MRI of the left shoulder revealed a relatively small full-thickness rotator cuff tear approximately 1.5 cm from the critical zone with little or no retraction. Dr. recommended continuing medications and 12 sessions of PT.

2011: From January through August, Dr. noted that the therapy was denied. He maintained the patient on medications.

From March through April, the patient attended 12 sessions of PT consisting of therapeutic exercises, manual therapy and ice.

In May, M.D., performed a DDE and assessed MMI as of May 6, 2011, with 2% whole person impairment (WPI) rating. In an FCE dated June 2, 2011, the evaluator felt that the patient could return to work without restrictions.

In August, M.D., performed a peer review and rendered the following opinions: (1) The treatment appeared reasonable. (2) No further PT modalities were reasonable. (3) Over-the-counter (OTC) pain medications could be useful to control shoulder pain, morning stiffness and pain with activity. (4) There was no indication for another shoulder surgery. (5) OTC ibuprofen or naproxen was reasonable.

Dr. noted moderate stiffness of the left shoulder and positive impingement and empty can sign with rotator cuff pain. He administered left subacromial space injection. Dr. noted no pain relief with the injection and continued medications.

On follow-up, Dr. noted that the injection caused increased swelling in the joint but no pain relief. He assessed rotator cuff tear and chronic left shoulder pain. He referred the patient to Dr..

M.D., obtained MRI arthrogram that revealed recurrent small rotator cuff tear with about 1-cm retraction and tendinosis or healed tear of the long head of biceps tendon.

2012: On January 24, 2012, Dr. performed arthroscopy of the glenohumeral joint with limited debridement, arthroscopy of the subacromial bursa with bursectomy and decompression and rotator cuff repair.

From January through April, the patient attended 24 sessions of postop PT consisting of therapeutic exercise, manual therapy, ice and hot pack.

On follow-up, Dr. noted pain in the upper chest along the pectoralis minor muscle. The patient reported that her shoulder was feeling too heavy. Dr. diagnosed post rotator cuff repair and adhesive capsulitis of the left shoulder and recommended continuing therapy and medications.

The patient underwent PT evaluation and was recommended 12 sessions of PT.

Per utilization review dated May 1, 2012, the request for 12 sessions of electrical stimulation, ultrasound, therapeutic exercise, therapeutic activities and manual therapy was denied with the following rationale: *"Claimant fell and injured her left upper extremity. She is status post left shoulder subacromial decompression and rotator cuff repair . The December 6, 2011, MR. arthrogram was interpreted*

as consistent with a small recurrent rotator cuff tear with about 1 cm of restriction, as well as tendinosis or healed tear of the long head of the biceps tendon. She is status post left shoulder arthroscopy and rotator cuff repair on January 24, 2012. She has completed 25 postoperative PT sessions following the most recent surgery. The April 26, 2012, PT evaluation documented complaints of arm weakness and soreness/swelling in the chest area. On exam, increased sensitivity to touch was noted over the glenohumeral joint. Restriction of passive range of motion was noted. "Complete weakness" of the arm was noted in all planes."

Dr. noted that the patient was evaluated by her family physician who told her that the breast pain was radiating from her shoulder along the muscle group. The patient was started on Naprosyn which had helped to a mild degree. There was some swelling in that area as well. Dr. recommended PT to increase ROM and strength.

PT, opined that the patient had extensive recovery but termination of her therapy at the last stage of recovery would reverse all the progress that had been made and might lead down a path of permanent limitations. She recommended continuing therapy to complete the last stage of rotator cuff rehabilitation. She felt that if this phase of recovery was not addressed, there would be further regression to functional decline with essential functions necessary for better quality of life.

Per reconsideration review dated May 15, 2012, the appeal for electrical stimulation, ultrasound, therapeutic exercise, therapeutic activities and manual therapy was denied with the following rationale: *"This female was injured on xx/xx/xx, while trying to break her fall and experienced left arm pain. The claimant subsequently underwent a rotator cuff repair of the left shoulder on February 23, 2010. The claimant postoperatively was rehabilitated appropriately but continued to have ongoing complaints and a subsequent revision rotator cuff repair of the left shoulder was performed on January 24, 2012. The claimant has now completed 25 sessions of physical therapy postoperatively with the April 26, 2012, PT note indicated the claimant has some restriction remaining passively. The active motion is 90 degrees flexion, 100 degrees abduction, 30 degrees external rotation and 42 degrees internal rotation. The medical records fail to document the rationale why the claimant needs additional physical therapy treatment and why she cannot perform self-directed home exercises to address any residual issues. At this time, after 25 sessions, the Official Disability Guidelines would not recommend ultrasound or electrical stimulation. For these reasons, the request does not meet ODG and non-authorization of the request is recommended."*

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

Based on ODG after twenty-five sessions of therapy, ultrasound and electrical stimulation are not recommended and therefore the decision was upheld.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**