

# MATUTECH, INC.

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## Notice of Independent Review Decision

**Date: September 17, 2012**

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

Additional 12 sessions of PT for right shoulder

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

Chiropractor

### **REVIEW OUTCOME:**

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

X Upheld (Agree)

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

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

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

The patient is a female who, sustained injuries to her right arm, elbow, shoulder, back and neck after long-term lifting. She developed pain in her right arm with numbness which increased to include right elbow, shoulder, back and neck.

Per DWC-73 dated April 18, 2011, the patient was evaluated by, D.C., for pain in her right arm with numbness which increased to include right elbow, shoulder, back and neck. She was diagnosed with bilateral lumbar sprain, right thoracic sprain/strain, right shoulder and upper arm sprain and unspecified mononeuritis of the upper limb. Dr. recommended physical therapy (PT) and ordered magnetic resonance imaging (MRI) of the right shoulder.

On May 11, 2011, D.O., evaluated the patient for right wrist/hand and shoulder pain that radiated to the right upper back/scapula area. The patient had LHL602.

numbness and tingling of the fourth and fifth fingers on the right. Examination of the right upper extremity showed shoulder pain, decreased strength, decreased sensory and positive apprehension, supraspinatus and Tinel's on the right. Dr. assessed right wrist and shoulder sprain/strain. He recommended continuing medications and obtained electromyography/nerve conduction velocity (EMG/NCV) of the upper extremities which was unremarkable.

MRI of the right shoulder showed the following findings: (1) Peritendinitis, inflammatory changes/tendinitis versus micro tear within cuff at its insertion; however, no full-thickness cuff tear was identified. (2) Irregularity and fraying involving the anterosuperior labrum, suspicious for injury to same and cystic changes within adjacent bony glenoid. (3) Mild acromioclavicular (AC) arthropathy and inflammatory changes with no frank medial arch narrowing. (4) Mildly low-lying acromion, with undersurface excrescences and mild lateral arch stenosis.

Per DWC-73 dated May 13, 2011, Dr. assessed bilateral lumbar sprain, right thoracic sprain/strain, right shoulder and upper arm sprain and mononeuritis of the upper limb. The patient was released to full-duty. At that time, no further medical care was anticipated.

In follow-up, Dr. reviewed the EMG and MRI finding. He assessed right shoulder internal derangement, right wrist sprain/strain, lumbar and cervical sprain/strain. He recommended physical performance evaluation (PPE).

In June, an orthopedic surgeon evaluated the patient for right shoulder complaints. He noted that the patient had completed two weeks of physical therapy (PT) and was performing her home exercise program (HEP). The patient had tried Vicodin, anti-inflammatory medications and activity modifications without significant relief of her pain. Examination of the right shoulder showed decreased range of motion (ROM), positive O'Brien, Hawkins and Neer's tests and a mildly positive drop arm test. Dr. assessed right shoulder strain, right scapula trigger point, rotator cuff tendinitis and labral tear. He prescribed a gel and Medrol Dosepak and recommended continuing PT and injections.

On follow-up, Dr. noted that the patient had ongoing shoulder pain. She reported no relief from tramadol. He recommended continuing rehab therapy.

From June through August, the patient attended multiple sessions of PT consisting of therapeutic activities and therapeutic exercises.

In August, Dr. noted that the patient had injection which did not provide much relief and the right shoulder pain was increasing. Dr. maintained the patient on naproxen, Ultracet and therapy.

In a functional capacity evaluation (FCE), psychological testing showed that the patient had 75% anxiety/depression. She was not capable of completing the job

duties without restrictions. The evaluator recommended referral to a specialist as well as follow-up with treating doctor for further future treatment recommendations.

On September 6, 2011, Dr. performed right shoulder arthroscopy, subacromial decompression, bursectomy, repair of superior labrum anterior-posterior (SLAP) tear with Mitek bioabsorbable anchor, intra-articular synovectomy and debridement of bursal sided rotator cuff tear and bone marrow aspiration and injection of bone marrow aspirate to the glenohumeral joint.

Postoperatively, Dr. noted that the patient felt little better. However, she had a lot of pain. She was utilizing an ultra sling. Dr. prescribed hydrocodone and recommended starting PT.

In an FCE performed in October, the patient demonstrated inability to perform her job duties without restrictions. The evaluator recommended postoperative therapy program and follow-up with the treating doctor.

From October 2011, through January 2012, the patient attended 24 sessions of postoperative PT consisting of therapeutic exercises and therapeutic activities.

In November, Dr. noted that the patient had ongoing shoulder pain with decreased function. She also complained of neck pain. Dr. refilled the medications and recommended continuing therapy.

**2012:** In a PPE performed on January 3, 2012, the psychological testing showed 80% of anxiety/depression. The patient demonstrated inability to complete the job duties without restrictions. The evaluator recommended follow-up with the treating doctor.

On follow-up, Dr. noted that the patient was very concerned about her right wrist pain. She was unable do anything due to pain in the right wrist/hand. She also had ongoing low back pain which radiated to the right hip. Therapy was ineffective. Dr. ordered MRI of the right wrist and lumbar spine.

On January 10, 2012, MRI of the right wrist showed the following findings: (1) Possible triangular fibrocartilage complex tear which could be confirmed with a conventional or MR arthrogram of the wrist. (2) Mild dorsal extensor compartment tenosynovitis. (3) Small volar carpal ganglion cyst. (4) Abnormal bone irritation and edema within the lunate and triquetrum, perhaps related to the patient's suspected triangular fibrocartilage complex tear. If an arthrogram study was performed, this could exclude an underlying lunotriquetral ligament tear as the source for the bone irritation. (5) There was a small 5 x 3 mm focus of reactive sclerosis likely due to a previous trauma or other insult within the distal radius.

MRI of the lumbar spine showed a broad 2 mm disc protrusion with mild bilateral neural foraminal narrowing at L5-S1.

On follow-up, Dr. noted that the patient had ongoing shoulder and back pain. She was attending PT. She had paresthesia in the shoulder blade. Dr. recommended right shoulder manipulation under anesthesia (MUA).

The repeat shoulder MRI was denied. The patient reported that topical medication was working best for pain relief. Dr. refilled topical medication and referred the patient for MUA.

In February, the patient was evaluated. The patient had increased pain in the right shoulder, right wrist, neck and low back.

On March 28, 2012, Dr. performed right shoulder arthroscopy, lysis of adhesions and MUA.

From April through May, the patient attended 14 sessions of postop PT consisting of therapeutic activities and therapeutic exercises.

In May, the patient was seen. It was noted that the patient's right shoulder was healing. She had a right shoulder pain, tightness and pain with lifting and decreased ROM. She had swelling in all the fingers of the right hand. She was utilizing hydrocodone. Examination of the right wrist showed positive Tinel's and positive ulnar nerve distribution. The patient reported dropping of things. She had decreased ROM and strength in the shoulder. She also has decreased sensation in the right upper extremity to pinprick. The patient was prescribed Norco, was recommended EMG of the bilateral upper extremities and additional therapy as she was unable to progress with HEP.

On June 7, 2012, a request was submitted for 12 sessions of PT for right shoulder consisting of therapeutic exercises and therapeutic activities.

On June 11, 2012, D.O., performed an EMG/NCV study of the bilateral upper extremities which were unremarkable. Dr. opined that there was suggestion of carpal tunnel syndrome (CTS) as the patient had reproduction of her hand symptoms with pressure over the carpal tunnel. Extension of the neck seemed to produce pain down the right arm and mild cervical radiculopathy could not be ruled out. A cervical spine MRI was recommended.

Per utilization review dated June 12, 2012, the request for 12 sessions of PT for the right shoulder was denied. The evaluator noted that the patient underwent post designated doctor exam on January 16, 2012, by Dr. who assessed MMI and assigned a 0% impairment rating (IR). There were multiple non-organic findings. The request for PT was denied with the following rationale: *"Attempts at peer to peer discussion were unsuccessful. The history and documentation do not objectively support the request for additional PT for 12 visits at this time. The claimant has attended postoperative PT but it is not clear how many visits were completed. There is no evidence of outlier status. The ODG allow up to 24 visits and Dr. stated she has attended 12 to date. The medical necessity of this request*

*has not been clearly demonstrated and a clarification or a modification was not obtained.”*

On June 25, 2012, Dr. noted that the patient had pain in the bilateral upper extremities. She had completed 15 out of 24 allowed postoperative rehab visits. Additional, rehab sessions were denied. Dr. recommended appealing for nine additional visits.

In a PPE performed on July 12, 2012, D.C., noted that the patient did not meet the requirements, safety and performance ability to do their job safely, effectively and confidently without restrictions. She was unable to perform her job duties without restrictions until she demonstrated objective improvement and the ability to perform safely and efficiently at her place of employment. He recommended a psychological evaluation, any referrals per treating doctor and postsurgical active therapy program.

On July 17, 2012, a request was submitted for 12 sessions of PT for the right shoulder consisting of therapeutic exercises and therapeutic activities.

Per reconsideration review dated July 24, 2012, the request for 12 sessions of PT for the right shoulder was denied with the following rationale: *“The request for 12 additional session of physical therapy to the right postsurgical shoulder is not established as medically necessary. ODG preface regarding physical therapy recommends an initial trial of 6 sessions over 2 weeks. And, with evidence of objective functional improvement, additional sessions may be appropriate. ODG for shoulder regarding physical therapy has recommendations for appropriate course of postoperative physical therapy. There was, however, no documentation regarding prior therapy and clinical outcomes. Peer to peer attempts were, also, unsuccessful. As such, there is insufficient clinical information to determine medical necessity for this request.”*

On July 30, 2012, Dr. noted that the patient neck pain going into the bilateral shoulders greater on the right side. She had completed 11 visits of postop rehabilitation. Examination of the right shoulder showed decreased ROM, pain on the posterolateral aspect of the shoulder and decreased strength. Dr. assessed shoulder internal derangement, right wrist internal derangement, cervical sprain/strain, lumbar radiculitis, status post right shoulder surgery and bilateral knee contusion. It was noted that the CCH had been reschedule three times. Dr. opined that the patient needed therapy and recommended follow-up. It was also noted that CCH was schedule for August 6, 2012.

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

This lady has several pre-existing conditions: the records provided reveal she has had bilateral surgery to her hands in 1999 – 2000. Then some sort of surgery to her arms in 2010 no specifics given. After this injury she went to 9 sessions of PT with no improvement. Injection to the right shoulder no success. She underwent

right shoulder arthroscopy, subacromial decompression, bursectomy, repair of superior labrum anterior-posterior (SLAP) tear. In which 24 additional sessions of PT were performed with no improvement. Another surgical procedure was performed on her right shoulder along with an MUA, 14 more PT Sessions were done with no improvement. A PPE performed in January of this year revealed and 80% anxiety/depression score. It appears that she has reached MMI. ODG allows for 24 PT sessions over a 14 week period for post surgical treatment of adhesive capsulitis. 14 sessions were documented over a five week period with no change in pain levels, no significant increase in ROM. No significant increase in Muscle strength. She has a high anxiety/depression score. Based on these factors as well as her previous track record of no improvement on any PT sessions. The request is denied.

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

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