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Notice of Independent Review Decision

April 3, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional Capacity Evaluation 97750 Left Shoulder

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

This physician is Board Certified in Physical Medicine and Rehabilitation with 18 years of experience.

REVIEW OUTCOME:

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

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. His shoulder was jerked. He was seen the next day.

Xx/xx/xx: Injury/Follow Up Appointment. **Evaluation:** Patient reports pain in left shoulder at 6 out of 10 and pain in Right hand at 8 out of 10. Pain increases with turning wrist and lifting. R Wrist: No swelling c/o pain to R wrist ROM and moderate palpation. L shoulder: No swelling c/o pain to raising arm overhead without pain in trapezius and lateral deltoid to moderate palpation. R wrist sprain L shoulder strain. **Plan:** Refer to PT, wear R wrist brace while awake.

09/20/2013: Progress Notes. **Subjective:** Patient reports doing a little better. **Objective Measurements:** Home program outlined. Modalities include: IFC

applied to the L shoulder x 15 min (97014x1) Therapeutic activities (97530x1): PROM of the L shoulder for all motions except ER- 5 min Therapeutic Exercise (97110x3) Theraputty yellow grip activities x 15 min, pully:flexion, abduction x 10 min, UBE, x 10 min, rows, lat pulls, blue tband, 3x10, x 5 min, phase 1, 4 direction, blue tband, 3x10, x5. **Plan:** Patient will be seen three times a week.

10/14/2013: MRI of the Left Shoulder Without Contrast interpreted. **Impression:** 1. There is tendinosis and peritendinitis of the supraspinatus tendon with full-thickness tear of the anterior supraspinatus tendon. 2. Mild arthritic changes of the glenohumeral joint. 3. Arthropathy of the acromioclavicular joint.

10/14/2013: MRI of the Right Wrist Without Contrast interpreted. **Impression:** 1. Mild tenosynovitis of the extensor carpi ulnaris tendon. 2. There is no fracture or dislocation.

10/18/2013: Patient Evaluation. **Subjective:** Patient is taking ibuprofen and muscle relaxers. His shoulder is getting worse. He does not feel therapy is effective. He would like to stop therapy at this point. He notes stiffness in the morning. He has trouble sleeping at night. He cannot sleep on his left shoulder. His pain is worse if he tries to perform any lifting. He is not able to carry out normal work duties or his daily activities. **Objective:** Physical examination shows the patient has findings compatible with a rotator cuff injury and impingement left shoulder. He has pain and palpable crepitus with elevating his arm above shoulder level. This pain and crepitus is improved in the palm up position as opposed to the palm down. There is tenderness to palpation at the AC joint. There is swelling and prominence of the AC joint. There is tenderness to palpation at the rotator cuff insertion. There is marked weakness with elevating the arm above shoulder level and in fact the patient requires assistance to achieve elevation of the arm above shoulder level. He cannot place his hand behind his head either with assistance or without assistance. He can touch his opposite shoulder. There is a positive crossed arm sign. He can place his hand behind his back. **Plan:** The patient advised of the pathology evident on his MRI scan report. An interpreter is utilized throughout the visit. He is encouraged to go ahead with a left shoulder excision distal clavicle, acromioplasty, and rotator cuff repair. Risks, indications, and alternatives are discussed along the surgery itself and postoperative course. He will need a prescription for pain medication of Norco 10 mg with 30 tablets and two refills after the proposed procedure.

11/06/2013: Progress Notes. **Subjective:** Patient underwent a L shoulder rotator cuff repair and Mumford procedure repair 11/5/13 and has been referred for physical therapy. Pt is currently not working. He currently has a nerve block on his L shoulder that is expected to come out 11/8/13. **Objective:** Patient reports pain in his L shoulder on a scale of 1-10, a 6/10 at rest. Palpation screen held secondary to recent surgery. AROM, HELD secondary to recent surgery, PROM, Shoulder, ABD 75/180, FLX 70/180 ER 1/90, Sensation, paresthesia L thumb, Strength, Left shoulder 1+/5, **Observation:** Patient walks with a stiff, protected, L shoulder girdle. Patient shows no L arm swing. The L arm is held in a protected position, flexed at the elbow 90 degrees and close by their side. Patient in an ABD

sling. Patient incision site covered by bandage, no overt sign of swelling or excessive redness. JAMAR GRIP R=100 lbs, L=40 lbs.

11/15/2013: Progress Notes. **Assessment:** Good tolerance to treatment. PROM FLX 95, ABD 110 pre-MT. FLX 105, ABD 115 post MT. Patient limited AROM and strength. **Plan:** Continue with current plan of care.

11/19/2013: Patient Evaluation. **Subjective:** The patient is here for recheck after surgery on his L shoulder on 11/5/13 with excision distal clavicle, acromioplasty, and rotator cuff repair. He reports he has been to therapy twice. A note from therapy states that his passive range of motion is flexion of 95 degrees with abduction of 110 degrees. His active ROM is flexion of 80 degrees with abduction of 55 degrees. **Plan:** The patient's sutures are removed. He will continue Physical Therapy.

11/20/2013: Progress Notes. **Subjective:** Patient reports that he is doing so much better with less pain and more movement. Reports that said that he could get rid of his sling unless in public with large crowd. **Assessment:** Patient is experiencing a decrease in signs and symptoms with improved strength and stabilization. Patient continues to complain of pain but objective signs are improving, with less pain. Patient reports improvement in symptoms and improved function since starting therapy. **Plan:** Progress with current plan of care.

11/27/2013: Progress Notes. **Subjective:** Patient reports that he is doing better with less pain overall and more movement. Pain rated at 2/10 with current activity. **Assessment:** Patient has been in physical therapy 7 visits for shoulder rehab. Objective measurements show improved shoulder PROM Flexion-130 degrees and ABD-135 degrees and improving shoulder strength. Jamar grip strength Right- 103 lbs and Left- 90 lbs. There is less muscle guarding and spasm and patient tolerates firmer soft tissue pressure. Patient has less pain, now a #2-3/10 with current restricted activity. Currently patient is not working due to surgery. Patient will benefit from structured PT to resolve these deficits and return to the previous level of functioning. **Plan:** Progress with current plan of care.

12/16/2013: Patient Evaluation. **Subjective:** This patient is here for recheck after surgery on his left shoulder on 11/5/13. A note from therapy states that he has nine visits remaining approved under his current series. His abduction is 155 degrees with flexion of 160 degrees. **Plan:** The patient will continue therapy at Physical Therapy. Work Status: The patient is on appropriate work restrictions of no pushing/pulling, no climbing stair/ladders, no reaching, no overhead, may not perform any lifting/carrying over 20 pounds, and desk work only.

12/30/2013: Patient Evaluation. **Subjective:** The patient is here for a recheck after surgery on his left shoulder on 11/5/13. A note from therapy states that he has been seen in PT for 20 visits and would benefit from FCE/work conditioning. **Objective:** Physical Examination shows his wounds to be benign. He moves his fingers well. ROM is abduction of 155 degrees with flexion of 160 degrees. He can place his hand behind his head. He can touch his opposite shoulder. He can place

his hand behind his back. **Plan:** The patient will continue therapy at Physical Therapy. Work Status: The patient is on appropriate work restrictions of no pushing/pulling, no climbing stair/ladders, no reaching, no overhead, may not perform any lifting/carrying over 20 pounds, and desk work only.

01/09/2014: Functional Capacity Evaluation. **Summary:** The client showed a need for improvement in the following areas: Left shoulder extension weakness, Left shoulder flexion weakness, Left shoulder endurance. It is strongly recommended that Mr. complete a work conditioning strengthening program for their Left shoulder with specific emphasis on Left shoulder to improve their overall torque, reduce risk for re-injury and enable them to return to their prior level of work duties. **Torque Results:**
R shoulder extension 70.40 foot-lbs which places him in the 96. percentile.
L shoulder extension 57.00 foot-lbs which places him in the 76. percentile.
R shoulder flexion 56.80 foot-lbs which places him in the 83. percentile.
L shoulder flexion 38.10 foot-lbs which places him in the 58. percentile. **Range of Motion:** was able to complete the entire ROM for both sides. This shows that they can attain enough ROM to complete their required job duties. **Right-Left Symmetry:** R flexion peak torque 56.80, L flexion peak torque 38.10, percentage 149%. R extension peak torque 70.40, L extension peak torque 57.00, Percentage 123%. **Flexor-extensor symmetry:** R flexion peak torque 56.80, R extension peak torque 70.40, Percentage 80%. L flexion peak torque 38.10, L extension peak torque 57.00, Percentage 66% **Work Fatigue:** L flexion work fatigue 18%, L extension work fatigue- 21%, R flexion work fatigue- 3%, R extension work fatigue- 6% **Strength as a proportion of body weight:** Body weight 202 pounds. Strength per body weight R shoulder ext 34.85. strength per body weight L shoulder ext 28.22, strength per body weight R shoulder flex 28.12, strength per body weight L shoulder flex 18.86.

01/27/2014: Progress Notes. **Subjective:** Patient reports that his shoulder is doing better with less pain and more movement. States that he wishes to be released following the completion of the work conditioning program. **Assessment:** Progressing with intensity of session, reports decreased pain post session at 2/10# and improved mobility and flexibility. Patient continues to complain of pain but objective signs are improving, with less pain, with current activity. Patient reports improvement in symptoms and improved function since starting therapy. **Plan:** Patient to complete 10 sessions of 3 hours each to progress to work related activities to improve endurance, strength, AROM to return to work.

01/30/2014: Progress Notes. **Subjective:** Patient reports that he is able to increase his activity level with less pain. Pain rated at 2-3/10 with current activity. **Assessment:** Progressing with intensity of session, reports decreased pain post session at 2/10# and improved mobility and flexibility. Patient continues to complain of pain but objective signs are improving with less pain with current activity. Jamar grip strength Right 115 lb. and left -114 lb. Patient reports improvement in symptoms and improved function since starting therapy and following the completion of the work conditioning program, pt wishes to be released. **Plan:** Patient to complete 10 sessions of 3 hours each to progress to

work related activities to improve endurance, strength, AROM to return to work. Continue as indicated by supervising therapist. Pt has 0 remaining sessions and then following completion of Work conditioning, an interim/Exit FCE will be performed.

02/10/2014: Patient Evaluation. **Subjective:** A previous note from therapy states that the patient has four remaining sessions and then will have an exit FCE performed. However, today we have contacted Physical Therapy and she states that she needs a note in addition to the previous Progress Encounter that was filled out and sent in to therapy. **Objective:** Physical Examination shows his wounds to be benign. He moves his fingers well. ROM is abduction of 155 degrees with flexion of 160 degrees. He can place his hand behind his head. He can touch his opposite shoulder. He can place his hand behind his back. **Plan:** The patient will continue his home exercise program. The patient does agree that he needs further rehabilitation before being released for his full duty work activities. A new prescription has been sent with the patient and will be sent by fax to his physical therapy for an FCE and possible work conditioning. **Work Status:** The patient is on appropriate work restrictions of no pushing/pulling, no climbing stair/ladders, no reaching, no overhead, may not perform any lifting/carrying over 20 pounds, and desk work only.

02/13/2014: UR performed. Rational For Denial: The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury, medications, and diagnoses were not provided within the available records. Surgical history includes a left shoulder rotator cuff repair with distal clavicle excision and acromioplasty on 11/05/2013. Other therapies include 24 sessions of postoperative physical therapy and 10 sessions of work conditioning. The patient is a male who reported an injury on xx/xx/xx. The Official Disability Guidelines do not require a Functional Capacity Evaluation for work conditioning programs. Guidelines recommend Functional Capacity Evaluations when there has been a prior unsuccessful return to work, there is conflicting medical reporting on precautions, and/or the patient is close to MMI. The notes submitted for review failed to indicate the patient is close to MMI. The notes submitted for review failed to indicate the patient has attempted return to work without success or is nearing MMI. Furthermore, the prior FCE was not submitted for review to assess results. As such, the request for repeat Functional Capacity Evaluation 97750 Left Shoulder is non-certified at this time.

03/10/2014: UR performed by Orthopedic Surgery. Rational for Denial: The clinical information submitted for review fails to meet the evidence based guidelines for the requested services. The mechanism of injury was not provided; date of injury xx/xx/xx. Medications were not provided. Surgical history includes left shoulder rotator cuff repair and Mumford procedure repair on 11/05/2013. Other therapies include the patient has completed 24 physical therapy sessions to date. The request was previously reviewed and denied on 02/12/2014. On the basis that the documentation failed to indicate the patient has attempted to return to work without success or is nearing MMI. On 1/09/2014, a Functional Capacity Evaluation was completed and it was determined that the patient showed a need

for improvement in the following areas: left shoulder extension weakness, left shoulder flexion weakness, left shoulder endurance. It was recommended that the patient complete a work conditioning strengthening program for the left shoulder with specific emphasis on left shoulder to improve overall torque, reduce risk for reinjury, and enable the patient to return to his prior level of work duties. The request to repeat the Functional Capacity Evaluation for the left shoulder is non-certified. In the request letter for the Functional Capacity Evaluation on 2/24/2014, The patient is able to move his fingers well. Range of motion is abduction of 155 degrees with flexion of 160 degrees. He can place his hand behind his head, touch the opposite shoulder and can place his hand behind his back. The treatment plan is for the patient to continue his home exercise program. Work status included is the patient is on appropriate work restriction of no pushing/pulling, no climbing stairs, ladders, no reaching, no overhead reaching, may not perform any lifting/carrying over 20 pounds, and desk work only. The official Disability Guidelines state that FCE should be considered if there were prior unsuccessful RTW attempts and if the patient is close or at MMI. The documentation provided failed to indicate that the patient had attempted to return to work without success or was nearing MMI; however, the prior FCE did not indicate any significant functional deficits and prescribed home therapy exercise program in place. As such, the request is non-certified.

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

Denial of Functional Capacity Evaluation is Upheld/Agreed Upon since there is lack of clinical information. ODG does not recommend FCE simply to determine return to work. Rather it is recommended for cases close to MMI and/or cases with complicated case management. The previous FCE on 1/9/14 only demonstrates left shoulder strength testing and deficits and no functional testing such as lifting capability. Therefore, a repeat of such a test after work conditioning is not beneficial with regards to decisions for return to function. There is also no information regarding completion and/or progress with work conditioning - no training numbers with weights and no endurance numbers to again determine necessity for further testing of functional capabilities. There is no mention of return to work plan; no job demands; no mention of whether there is a job to return to. For this reason a Functional Capacity Evaluation 97750 Left Shoulder is not medically necessary at this time and is denied.

PER ODG:

Guidelines for performing an FCE:

Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job.

If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive.

It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants.

Consider an FCE if

1) Case management is hampered by complex issues such as:

- Prior unsuccessful RTW attempts.

- Conflicting medical reporting on precautions and/or fitness for modified job.
 - Injuries that require detailed exploration of a worker's abilities.
- 2) Timing is appropriate:
- Close or at MMI/all key medical reports secured.
 - Additional/secondary conditions clarified.
- Do not proceed with an FCE if
- The sole purpose is to determine a worker's effort or compliance.
 - The worker has returned to work and an ergonomic assessment has not been arranged. (..)

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)