Health Decisions, Inc.

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Notice of Independent Review Decision

April 27, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical Therapy 3 X 6 Right Shoulder

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

America Board of Physical Medicine and Rehabilitation physician with over 16 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 that was injured at work on xx/xx/xx. He got hit right arm and crushed the right upper extremity. He ended up with a right above-the-elbow amputation the day after the injury. The claimant's right shoulder was also injured because it was forced into hyperextension when the arm was pulled backwards. The claimant has completed 12 PT sessions and is taking pain medications, but still does not have FROM of his right shoulder.

10-31-13: Ortho Operative Report. Pre-op Diagnosis: Right elbow open wound. Post-op Diagnosis: Same. Procedure: Excisional debridement skin, muscle, bone.

11-02-13: Ortho Operative Report. Pre-op Diagnosis: Right upper extremity crush injury. Post-op Diagnosis: Same. Procedure: Debridement and irrigation right upper extremity skin, muscle, bone.

11-04-13: XR Chest 1 View. Impression: 1. Well positioned left PICC. 2. Bibasilar atelectasis.

11-04-13: Ortho Operative Report. Pre-op Diagnosis: Right transhumeral amputation. Post-op Diagnosis: Same. Procedure: Debridement and irrigation of skin, muscle and bone of upper extremity.

01-30-14: Office Visit Report. The claimant presents with c/o pain in the stump as phantom pain and limitation of motion of right shoulder. He has not had physical therapy. Upon examination, the right upper extremity reveals significant amount of tenderness all around the shoulder, upper arm, end of the stump and along the lateral aspect of the upper arm. The claimant has significant limitation on ROM of the shoulder with abduction and forward elevation that is only 60 to 70 degrees each way. X-rays of the shoulder are WNL. X-ray of humerus reveal some soft tissue calcification at the distal end of the humerus. Impression: 1. Above-elbow amputation. 2. Rule out rotator cuff tear. Recommendations: Start PT and get MRI of the shoulder.

02-03-14 thru 03-05-14: PT Notes. Diagnosis: Right shoulder pain/rotator cuff tendonitis. ROM over right shoulder: Active: FF 0-30 deg., abduction 0-20 deg. with pain during movement. Passive: FF 0-80 deg., abduction 0-70 deg. Repeated movement examination reveals contractile dysfunction (rotator cuff tear syndrome) as well as articular dysfunction (frozen shoulder). Joint mobility as majorly decreased to interior glides over right shoulder. Palpation reveals significant muscle tenderness over right deltoid, scapular and supraspinatus muscle groups. Strength for FF 3-/5, abduction 3-/5 with pain during movement. Palpation reveals significant hypersensitivity over right UE stump. Assessment: Contractile and shoulder dysfunction syndrome with significant loss of functional abilities. Goals: 1. Normalize right shoulder active and passive ROM. 2. Independent with HEP. 3. VAS score of 0/10. 4. Normalize joint mobility. 5. Return to prior level of function. 6. Strength to equal 5/5 without pain during movements.

02-06-14: MRI Right Shoulder without Contrast. Impression: 1. Normal examination of the osseous structures. 2. No signs of injury to the rotator cuff. 3. Thickened inferior scapular recess, finding which may be a normal variant in a young patient or may represent adhesive capsulitis. Clinical correlation is necessary. 4. Small joint effusion.

02-10-14: Office Visit Report. The claimant presents with discomfort in the amputated limb with some type of phantom pain with limitation of motion and pain in the shoulder. Upon examination, the claimant has quite a bit of limitation, especially abduction and forward elevation and is sensitive over the stump. Recommendations: Continue PT.

03-03-14: Re-Evaluation/Progress Report. The claimant has completed 11 of 12 PT sessions. He reports decreased pain levels VAS score of 6/10 worse and 2/10 best. Improvement is best over right UE and scapular areas. He is better able to sleep and is doing well with his home exercise program with good compliance. Upon examination, ROM over right shoulder: Active FF 0-130 deg. (0-30 deg. at initial visit), abduction 0-110 deg. (0-20 deg. at initial visit) with pain during movement. Passive FF 0-150 deg. (0-80 deg. at initial visit), abduction 0-144 deg. (0-70 deg. at initial visit). Repeated movement exam reveals contractive dysfunction (rotator cuff tear syndrome) and articular dysfunction (frozen shoulder). Joint mobility is moderately decreased to inferior glides over right shoulder. Palpation reveals moderate muscle tenderness over right deltoid, scapular, supraspinatus muscle groups and a moderate amount of hypersensitivity over right UE stump. Strength for FF 3-/5, abduction 3-/5 with pain during movement. Goals: 1. Normalize right shoulder active and passive ROM. 2. Independent with HEP. 3. VAS score of 0/10. 4. Normalize joint mobility. 5. Return to prior level of function. 6. Strength to equal 5/5 without pain during movement. Plan of Care: TE, NMR, MTT, Functional/Kinetic Activities, HEP, Ultrasound, PT re evaluation. 3 times 4 weeks.

03-10-14: Office Visit Report. The claimant presents with pain both in the shoulder and in the stump with a phantom type of pain. He is making slow but steady progress. He has stopped PT and improves with medication (Hydrocodone and gabapentin). Upon examination, the claimant has better ROM, but with limited abduction and forward elevation. Some crepitance is present and stump only tender at very tip. Recommendations: Continue ROM and home exercise program.

03-18-14: URA. Rationale: Based upon the medical documentation presently available for review, the above noted reference would not support this specific request, as submitted, to be on of medical necessity. The requested amount of physical therapy services would exceed the amount supported per criteria set forth by the above noted reference. As a result, medical necessity for this request is not established for the described medical situation.

03-25-14: Letter for Appeal. In opinion, the claimant's injury itself plus the amount of pain associated with the amputation and the period of time in which he could not use the arm are responsible for the significant limitation of motion. Anybody familiar with musculoskeletal disorders, this type of adhesive capsulitis requires prolonged physical therapy as the mainstay of treatment. Without appropriate functional range of motion of the shoulder, the claimant undoubtedly will have more disability than he has already had due to his amputation. It is important to note that the longer he delays his therapy, the less likely that he will tolerate his range of motion.

03-27-14: Office Visit Report. The claimant presents with pain to the stump which has improved and has decreased with the frequency of pain medicine and neuralgia medicine. Upon examination, he has improved ROM, but still has a

limitation with abduction and forward elevation. Plan: Instructed the claimant to not wait to begin ROM, exercises shown to begin to help increase ROM and follow up with PT.

04-02-14: URA. Rationale: There was an adverse determination for this request previously denied on 03-18-14. As per the ODG guidelines, the recommended number of visits for rotator cuff syndrome is 10 visits over 8 weeks. The patient was initially certified for 12 visits and has completed 11 already. In that time the patient has shown improvement in the shoulder ROM, but the patient has not been able to improve the strength in resistive ROM. There was an MRI study performed on 02-06-14 revealing evidence of tendinitis without any tears in the rotator cuff. The patient has been given a home exercise program and it was noted that the patient is compliant with that program. It is unclear why the patient showed no progression in strength. Since there is no improvement in the patient's strength after 11 sessions, it is recommended to non-certify the additional 18 PT sessions.

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

Denial of an additional 18 visits of PT specifically to the Right Shoulder is UPHELD/AGREED UPON. After 12 visits the claimant has made gains in active range of motion but no gains in strength. Sixteen visits is excessive given this rate of progress. The claimant has been instructed in a home exercise program. Any further recovery will likely occur with a vigorous daily exercise program at home rather than 2 or 3 visits weekly. There is no indication for additional PT visits at this time. The request for 12 sessions of physical therapy for the right shoulder is denied.

Per ODG:

Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Use of a home pulley system for stretching and strengthening should be recommended. (Thomas, 2001) For rotator cuff disorders, physical therapy can improve short-term recovery and long-term function. For rotator cuff pain with an intact tendon, a trial of 3 to 6 months of conservative therapy is reasonable before orthopaedic referral. Patients with small tears of the rotator cuff may be referred to an orthopaedist after 6 to 12 weeks of conservative treatment. The mainstays of treatment for instability of the glenohumeral joint are modification of physical activity and an aggressive strengthening program. Osteoarthritis of the glenohumeral joint usually responds to analgesics and injections into the glenohumeral joint. However, aggressive physical therapy can actually exacerbate this condition because of a high incidence of joint incongruity. (Burbank, 2008) (Burbank2, 2008)

Impingement syndrome: For impingement syndrome significant results were found in pain reduction and isodynamic strength. (Bang, 2000) (Verhagen-Cochrane, 2004) (Michener, 2004) Self-training may be as effective as physical therapist-supervised rehabilitation of the shoulder in post-surgical treatment of patients treated with arthroscopic subacromial decompression. (Anderson, 1999) A recent structured review of physical rehabilitation techniques for patients with subacromial impingement syndrome found that therapeutic exercise was the most widely studied form of physical intervention and demonstrated short-term and long-term effectiveness for decreasing pain and reducing functional loss. Upper quarter joint mobilizations in combination with therapeutic exercise were more effective than exercise alone. Laser therapy is an effective single intervention when compared with placebo treatments, but adding laser treatment to therapeutic exercise did not improve treatment efficacy. The limited data available do not support the use of ultrasound as an effective treatment for reducing pain or functional loss. Two studies evaluating the effectiveness of acupuncture produced equivocal results. (Sauers, 2005)

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)
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). Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasonography, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapy providers available for referral.
See also more specific listings: Activity restrictions; Acupuncture; Bipolar interferential electrotherapy; Biofeedback; Biopsychosocial rehab; Cold lasers; Cold packs; Continuous-flow cryotherapy; Continuous passive motion (CPM); Cutaneous laser treatment; Deep friction massage; Diathermy; Dynasplint system; Electrical stimulation; Ergonomic interventions; ERMI Flexionater®/ Extensionater®; Exercises; Flexionators (extensionators); Graston instrument assisted technique (manual therapy); Home exercise kits; Ice packs; Interferential current stimulation (ICS); Iontophoresis; Kinesio tape (KT); Low level laser therapy (LLLT); Manipulation; Massage; Mechanical traction; Neuromuscular electrical stimulation (NMES devices); Occupational therapy; Polar care (cold therapy unit); Range of motion; Return to work; Static progressive stretch (SPS) therapy; TENS (transcutaneous electrical nerve stimulation); Thermotherapy; Ultrasound, therapeutic; Work; Work conditioning, work hardening.

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-injection treatment: 1-2 visits over 1 week
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):
Medical treatment: 16 visits over 8 weeks

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)