

# Vanguard MedReview, Inc.

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## Notice of Independent Review Decision

October 7, 2014

### IRO CASE #:

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

Physical Therapy X 24 97113, 97110, 97112, 97530, 97140, Lt Shoulder

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

This physician is a Board Certified Orthopedic Surgeon with over 42 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.

### PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx when she had a fall while working.

06/28/2013: History and Physical. **HPI:** The patient had an anterior shoulder dislocation on the left when she had a slip and fall at work. She had an immediate onset of pain. Apparently, it was either a difficult reduction or it was hard to maintain reduction according to family. She came in for evaluation. **Radiographs ordered/reviewed:** Radiographs show a nicely located glenohumeral joint. Impression: Shoulder dislocation. **Treatment Plan:** We need an x-ray again in 1 week, just a one-shot AP to make sure it has maintained reduction and then 1 week after that I want to get another AP shoulder. At that point, we will get her into physical therapy and get the arm moving, but I want to try to get her a little bit stiffer for the first 3 weeks.

07/08/2013: Follow Up Evaluation. **Subjective:** She had a dislocation of the shoulder. She is 1 week out. **Radiographs ordered/reviewed:** X-rays show nice reduced shoulder. **Treatment Plan:** We will see her back in 1 week for AP and lateral x-rays. We can start working on ROM at that point.

07/18/2013: Follow Up Evaluation. **Subjective:** She had a dislocation of her shoulder. She is doing very well. She still has some tenderness over the shoulder, otherwise neurovascularly intact. **Radiographs ordered/reviewed:** X-rays show nice reduced shoulder. **Treatment Plan:** I recommend physical therapy. She is to avoid abduction and external rotation. She can do active range of motion only. We will see her back in 4 weeks for reevaluation. We need AP x-rays on her shoulder on return.

08/15/2013: Follow Up Evaluation. **Subjective:** She has left shoulder pain. She had a dislocation of the shoulder. She is doing well. She has been doing some physical therapy. **Treatment Plan:** We are going to begin a more active rotator cuff program. She has complete weakness throughout the cuff and really has almost no activation of the supraspinatus and external rotators. I am going to have her work on those aggressively. I went over this specifically with her. In addition, we will have the therapist work aggressively on it. Apparently, she has had 14 sessions of physical therapy authorized. She is nowhere near being close to being functional with this arm. She cannot abduct or flex even greater than 30 degrees. She will definitely need more therapy. I discussed with her there is still the possibility of rotator cuff tear, but I need her to start getting some strength in the shoulder. Even if I knew today that there was a rotator cuff tear, she is so weak I would hate to set her back further. I would like for her to start getting strength in the rest of the rotator cuff. We will make some determinations whether or not we will need an MRI if we are not making good progress with physical therapy and the plan discussed today.

10/02/2013: MRI Left Shoulder Without Contrast. **Impression:** 1. Massive full thickness rotator cuff tear involving the supraspinatus and ventral infraspinatus tendons as well as the subscapularis tendon. All of the tendons are retracted at least 4cm to the edge of the glenohumeral joint, and there is severe atrophy and fatty infiltration within all three muscle bellies. 2. The long head of the biceps tendon is dislocated into the ventral aspect of the shoulder secondary to the subscapularis tear. It still attaches to the superior labrum as expected. 3. Mild osteoarthritic changes in the inferior aspect of the glenohumeral joint. 4. Severe AC joint hypertrophy with inferior osteophytic spurring together with a moderate sized broad-based subacromial spur which abuts the superiorly migrated humeral head. 5. Moderate amount of subacromial subdeltoid bursitis. 6. Of all the multiple repeats, those with the least amount of motion are submitted for review. It is suboptimal, but still diagnostic of the above findings.

10/04/2013: Follow Up Evaluation. **Subjective:** She has not really had excellent response to the therapy. **Physical Examination:** Her flexion and abduction actively is terrible, maybe about 20 or 30 degrees. **Radiographs ordered/reviewed:** The MRI does confirm our suspicion. She has a massive

rotator cuff tear, 4 cm of retraction. **Treatment Plan:** This is going to be a very difficult reconstruction. Although we are going to make an attempt at arthroscopic reconstruction, we need to be prepared for an open reconstruction, even graft jacket. I have discussed with her that there is a possibility that these are non-repairable tears at this point. There are degenerative changes throughout, but this is really noting that is acute. The acute issue is the rotator cuff tear which has affected her function. She was perfectly functional before with no painful ROM and function. Now, she has pain with poor function of the shoulder. Subacromial compression will need to be done at that time as well to make space for the rotator cuff anchors/sutures and possibly even for graft jacket. Risks and benefits were discussed with the patient in detail. We will schedule her for this as soon as we can. Follow up post op.

11/08/2013: Operative Report. **Post-Operative Diagnoses:** 1. Massive left shoulder rotator cuff tear. 2. Subacromial impingement, left shoulder. 3. Large tear of the glenohumeral labrum. **Procedure:** 1. Open left rotator cuff repair. 2. Use of allograft dermal tissue for repair. 3. Left shoulder arthroscopy with arthroscopic extensive labral debridement. 4. Left shoulder arthroscopy with arthroscopic subacromial decompression.

12/05/2013: Follow Up Evaluation. **Subjective:** The patient had a massive rotator cuff tear of the left shoulder, which was repaired on 11/08/2013 with a graft jacket. She still has some aches and pains not unexpectedly. **Physical Examination:** Passive ROM is improving nicely. She is doing pendulums, but actively very significant weakness. **Treatment Plan:** We are going to begin 4 weeks of isometrics. We are going a little bit slowly with her because of the graft jacket. I will see her back in 4 weeks to begin an active rotator cuff program in physical therapy. She can return back to work on a limited fashion if available.

01/09/2014: Follow Up Evaluation. **Subjective:** The patient comes in status post open rotator cuff repair with graft jacket. She continues to improve. She really has not started any outpatient physical therapy. **Physical Examination:** Her motion is still limited. Actively about 90 degrees and forward flexion and abduction. Still limited in external and internal rotation. Neurovascularly intact. Strength is still 3/5. **Treatment Plan:** She needs to work aggressively with physical therapy working on ROM. No use of the left arm. She is to do limited duties at work. We will see her back in 6 weeks and advance activities at that time.

04/03/2014: Office Visit. **Left Shoulder Exam:** Active extension 0 degrees. Active Flexion 90 degrees. Passive extension/flexion is full. ROM: Active Internal Rotation: 10 degrees. Active External Rotation: 10 degrees. Strength Testing: External Rotation: 3/5 Internal Rotation: 3/5 Supraspinatus: 3/5 Forward Flexion: 3/5 **Assessment:** 1. Added Sprain and strain OTH Spec sites shoulder & Upper arm **Plan:** With this type of injury, she will need a lot more therapy just to get to where she is functional. She is currently doing PT at home as well as outpatient PT. It is medically necessary and critical for her to continue PT. We will check her back every week to check improvement.

05/21/2014: MRI of the left shoulder without contrast. **Impression:** 1. No interval change in the massive full thickness rotator cuff tear of the supraspinatus and infraspinatus tendons retracted 4 cm to the level of the glenohumeral joint with severe atrophy and fatty infiltration within the muscle bellies. 2. Additionally noted is a stable complete tear of the subscapularis tendon retracted to the level of the glenohumeral joint with atrophy and fatty infiltration within the ventral aspect of the shoulder secondary to the subscapularis tear. It still attaches to the superior labrum. 4. Stable moderate osteoarthritic changes in the inferior aspect of the glenohumeral joint. 5. Stable severe atrophy and inferior osteophytic spurring together with a moderate to large broad-based subacromial spur which abuts the superiorly migrated humeral head. 6. Stable moderate amount of subacromial/subdeltoid bursitis. 7. The study is borderline diagnostic because of motion. All the sequences were repeated multiple times. Those with least amount of motion are submitted for review. It is still diagnostic of the above findings.

06/05/2014: Follow Up Evaluation. **Subjective:** She comes in with continued complaints of left shoulder pain. I have had extensive discussions with her regarding her left shoulder and spent over 45 minutes in the office today going over them with her again. I explained to her that she had a very bad issue with her shoulder. As I discussed from the time of surgery, and I reviewed the operative report with her, there were a lot of chronic changes seen. She had very poor tissue, a rotator cuff that was retracted, atrophied, and not able to be mobilized. The muscle quality was so poor that I dictated at the time that the likelihood of requiring reverse Arthroplasty would be high if she remained symptomatic. At this point she has. She made essentially a Hail Mary attempt at a reconstruction with a graft jacket and it has not worked for her. In some patients they work extremely well and some they do not. **Treatment Plan:** At this point, she has done extensive physical therapy. I do not think any further physical therapy formally is really required at this point. She can do as much therapy as she wants on her own; that that is reasonable. She reports she has made progress from one month to the next, and although it is minimal it has been slow and steady. I told her that really at this point she needs to understand that the only thing she has left is giving it more time to allow this to continue to improve. She has not plateaued and although the improvement is very slow, it is improvement nonetheless. The alternative is a reverse shoulder Arthroplasty. This may improve her biomechanics of the shoulder and allow for better functional use, but at this point she can do limited use of the left shoulder. No overhead lifting clearly and no lifting of the toddlers. Other than that, I have no further restrictions. No further follow up is required by me. I was referring her for consideration of reverse shoulder Arthroplasty. She continued to ask me a multitude of questions regarding that procedure in detail, and I asked her to save it for the surgeon who will be doing the procedure, as he is better versed in it than I.

07/08/2014: Initial Evaluation. **HPI:** The patient indicated that the affected shoulder feels weak, aches and tingling or numbness in fingers. She indicated that they had shoulder pain while getting a parking ticket from a machine, putting on a seatbelt, turning the car steering wheel, performing gardening or yard work, performing housework, vacuuming, doing the laundry, putting on a coat or

sweater, fastening bra, combing or drying hair, lifting, pushing or pulling, typing or doing computer work, pouring tea or milk from a pitcher, getting mild from refrigerator shelf, reaching overhead, reaching out to side, carrying heavy objects and showering. **Exam:** Left Shoulder Atrophy: Supraspinatus atrophy is present, infraspinatus atrophy present, mid-third deltoid muscle atrophy is present, anterior third deltoid muscle atrophy is absent and posterior third deltoid muscle atrophy is absent. Active ROM: forward flexion=0 degrees and abduction=0 degrees. External rotation with the arm at side=20 degrees. Internal rotation to lumbosacral junction. Passive ROM: Normal and symmetrical. Neurovascular examination: normal. Rotator cuff testing: Lift off test was negative. Belly press test was negative. Jobe test was positive for weakness. External rotation lag sign was positive. Horn blower sign was negative. **Left Anterior-Posterior Radiographic findings:** Superior migration of the humeral head. Glenohumeral joint space was decreased. **Left Axillary radiographic findings:** glenohumeral joint space was decreased. **Left Scapular Outlet radiographic findings:** Type 2 acromion. **MRI Study: Supraspinatus:** retraction to level of glenoid rim, Grade 4 muscle atrophy, full-thickness tear and Fatty Infiltration. **Infraspinatus:** Fatty infiltration, full-thickness tear and retracted to level of glenoid rim. **Teres minor:** normal. **Subscapularis:** Full thickness tear of the superior 1/3 of the subscapularis tendon. No muscle atrophy. **Impression-L Shoulder/Arm:** Rotator Cuff Arthropathy **Plan L Shoulder/Arm: Surgery recommended:** Reverse prosthesis. Selective rest. Hydrotherapy. Prior to surgery patient will need SHOUT outcomes. Activity modification. Physical therapy. Return to the office in 2 months. If symptoms continue or increase consider surgical correction.

07/30/2014: UR performed by M. **Rationale for Denial:** The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The mechanism of injury was a fall. Medications were not stated. Surgical history included massive rotator cuff repair on 11/08/2013. Diagnostic studies included as an x-ray dated xx/xx/xx that documented there was an anterior glenohumeral joint dislocation; and an x-ray post reduction dated xx/xx/xx that documented anatomic alignment at the glenohumeral articulation with no evidence of fracture; an MRI dated 02/20/2013 that concluded there was a massive full thickness rotator cuff tear with a dislocation long head biceps tendon of the left shoulder. Other therapies included physical therapy, corticosteroid injections, and a work hardening program. The patient is a female who reported an injury on xx/xx/xx. Physical therapy shoulder evaluation and plan of care dated 07/25/2013 documented that the patient had a continued pain complaints rated 2/10 with left shoulder ROM described as 57 degrees in flexion and 56 degrees in abduction. It was also noted that the patient had significant motor strength weakness rated at a 2-/5. Additional physical therapy was requested. Official Disability Guidelines recommend up to 40 visits of physical therapy in the post-surgical management of rotator cuff repair after a complete rupture. The clinical documentation submitted for review does indicate that the patient has already participated in at least 24 visits of postoperative physical therapy without significant functional benefit. It is also noted within the documentation that the patient has participated in a work hardening program. The submitted documentation does not clearly provide any justification to support additional

physical therapy in combination with the already provided treatment. Furthermore, the requested additional 24 sessions in combination with the already completed 24 sessions exceeds guideline recommendations. I discussed the case who had no additional clinical information to provide. As such, the requested physical therapy x 24 for the left shoulder is non-certified.

08/04/2014: Letter. Please be advised that I consider it medically necessary to have aquatic therapy. currently has rotator cuff Arthropathy and with that does not have any active shoulder motion. I believe that she may benefit from aquatic therapy to regain some active motion. may require the need for surgical intervention to alleviate shoulder problems, which would also include post-operative physical therapy. At this time, we would like to try conservative treatment in hopes to avoid a future surgery.

08/13/2014: UR. The patient is a female who sustained an injury on xx/xx/xx; after she slipped and fell (as per report dated 6/28/13). She is currently diagnosed with shoulder joint pain and left shoulder rotator cuff Arthropathy. An appeal request for 24 visits of physical therapy for the left shoulder is made. The previous request was non-certified based on the grounds that the clinical documentation submitted indicate that the patient has already participated in at least 24 visits of postoperative PT without significant functional benefit; that it is also noted within the documentation that the patient has participated in a work hardening program; that the submitted documentation does not clearly provide any justification to support additional PT in combination with the already provided treatment; and that the requested additional 24 sessions in combination with the already completed 24 sessions exceeds guideline recommendations. Updated documentation submitted for review includes the evaluation summary/plan of care dated 7/25/14, left shoulder MRI report dated 5/21/14 and correspondence/note dated 8/4/14. These did not address the above-mentioned reasons for non-certification. The records indicate that the patient has had multiple left shoulder procedures including shoulder reduction; open left shoulder rotator cuff repair with arthroscopic extensive labral debridement and subacromial decompression on 11/8/13; and fraft jacket reconstruction. Other applications and Work Hardening. Prior diagnostic examinations performed include x-ray and MRI studies. The left shoulder MRI study dated 5/21/14 showed no interval change in the massive full-thickness rotator cuff tear of the supraspinatus and infraspinatus tendons retracted 4 cm to the level of the glenohumeral joint with severe atrophy and fatty infiltration within the muscle bellies; stable complete tear of the subscapularis tendon retracted to the level of the glenohumeral joint with atrophy and fatty infiltration; dislocated long head of the biceps tendon in the ventral aspect secondary to the subscapularis tear; stable moderate osteoarthritic changes in the inferior aspect of the glenohumeral joint; and stable severe atrophy and inferior osteophytic spurring with a moderate to large broad-based subacromial spur which abuts the superior migrated humeral head; and stable moderate amount of subacromial/subdeltoid bursitis. In the report dated 6/5/14, the provider stated that the patient has done extensive physical therapy. The provider mentioned that he does not believe that any further physical therapy formally is really required at this point. The shoulder evaluation/care plan report dated 7/25/14 states that the

patient complains of pain in the left shoulder and wrist, pain and difficulty with lifting and reaching, decreased mobility in the shoulder and numbness in the left hand fingertips. Her main functional deficits include lifting, reaching, grooming, household chores and yard work. Physical examination of the left shoulder showed active flexion of 57 degrees, abduction of 56 degrees, external rotation of 59 degrees at 90 degrees, and motor strength of 2/5. Physical therapy was recommended (24 visits). In the note dated 8/4/14, the provider recommended Aquatic Therapy. It was mentioned that the patient currently has rotator cuff Arthropathy and with that, does not have active shoulder motion. Aquatic therapy may enable her to regain some active motion. She may need surgical intervention to alleviate shoulder problems, which would include post-operative physical therapy. Conservative treatment is recommended at this time in the hopes to avoid a future surgery. Although the previous determination stated that the patient has had at least 24 visits of postoperative physical therapy as well as work hardening program, the records submitted did not mention the total number of post-operative physical therapy visits completed to date. Documentation of the completed WHP was not provided for review as well. Only four therapy visits were documented from 1/20/14 to 4/24/14. The reason why the patient still has significant functional deficits was not addressed. The need for 24 additional sessions at this time could not be determined as well given the lack of information from the completed post-operative rehabilitation. I discussed the case who indicated there was not any additional clinical information available to support this request. With these reasons, the medical necessity of the requested 24 visits of Physical Therapy for the left shoulder is not established in agreement with the previous determination.

08/21/2014: Office Visit. **L Shoulder History:** Aquatic PT denied by work comp. The patient feels that the pain has not changed with time, the function of the shoulder is worse, states that the shoulder movement is worse, feels that eth strength is decreasing and stability unchanged. **Active ROM:** forward flexion=0 degrees. External rotation with the arm at side=20 degrees. Internal rotation to lumbosacral junction. **Plan L Shoulder/Arm:** Since all appropriately ordered aquatic PT has been denied by work comp, only other option for this patient to achieve active elevation is reverse shoulder Arthroplasty followed by postoperative rehabilitation. Will order a home program at patient's request. Selective rest. Hydrotherapy. Prior to surgery patient will need SHOUT outcomes. **Surgery recommended:** Reverse prosthesis. Activity Modification. Physical Therapy. Return to office only if needed. If symptoms continue or increase consider surgical correction.

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

The previous adverse determinations are upheld. She had 24 treatments without any improvement post op. Her post op MRI shows failure of the repair. Although ODG indicate up to 40 treatments, since she has made no progress it would not be reasonable. There is no medical probability that further PT would be beneficial.

For these reasons, Physical Therapy X 24 97113, 97110, 97112, 97530, 97140, Lt Shoulder is not medically necessary at this time and should be denied.

Per ODG:

**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

Post-surgical treatment: 24 visits over 14 weeks

**Dislocation of shoulder (ICD9 831):**

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

**Acromioclavicular joint dislocation (ICD9 831.04):**

AC separation, type III+: 8 visits over 8 weeks

**Sprained shoulder; rotator cuff (ICD9 840; 840.4):**

Medical treatment: 10 visits over 8 weeks

Medical treatment, partial tear: 20 visits over 10 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks

**Superior glenoid labrum lesion (ICD9 840.7)**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (labral repair/SLAP lesion): 24 visits over 14 weeks

**Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified) (ICD9 714.0; 715; 715.9; 716.9)**

Medical treatment: 9 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks

**Brachial plexus lesions (Thoracic outlet syndrome) (ICD9 353.0):**

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

**Fracture of clavicle (ICD9 810):**

8 visits over 10 weeks

**Fracture of scapula (ICD9 811):**

8 visits over 10 weeks

**Fracture of humerus (ICD9 812):**

Medical treatment: 18 visits over 12 weeks

Post-surgical treatment: 24 visits over 14 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)**