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July 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy 12 sessions to the right shoulder

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

Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

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 patient is a male who twisted his left knee during retrieval of an x at work on xx/xx/xx. He also fell on his right shoulder.

On August 27, 2013, the patient was seen for complaints of left knee pain. Previous treatment had been with a left hinged knee brace, ice packs, elevation, rest and a history remarkable for left anterior cruciate ligament (ACL) reconstruction in 2008 and a left shoulder surgery. The assessment was internal derangement of the left knee.

On August 30, 2013, magnetic resonance imaging (MRI) of the left knee revealed a tear of the ACL graft, joint effusion and well maintained patellofemoral cartilage, bone contusion of the posterolateral tibial plateau and no appreciable medial or lateral meniscal tear.

saw the patient on September 4, 2013, and noted the physical exam of the left knee was normal. He reviewed the MRI findings and diagnosed left knee pain and ACL sprain/tear. Surgical versus non-surgical options were discussed. He gave a prescription for physical therapy evaluation and treatment.

On September 20, 2013, MRI of the right shoulder revealed a large full-thickness tear of the entire supraspinatus tendon with retraction of the tendon to 1 o'clock. There was mild muscle atrophy. There was 75% partial tear of the subscapularis tendon with prominent muscle atrophy. There was likely a combination of articular-sided partial-thickness tearing and some minimal full-thickness tearing of the infraspinatus tendon. There was poorly visualized biceps tendon within the bicipital groove as well as within the joint. Its attachment at the superior labrum was not seen. There was diffuse degeneration and tearing of the superior labrum and inferior labrum.

On September 25, 2013, the patient underwent initial physical therapy evaluation for the left knee and was recommended therapy two times a week for four weeks.

From October 2, 2013, through October 25, 2013, the patient underwent eight therapy visits. The modalities utilized were therapeutic exercises and neuromuscular re-education.

On October 2, 2013, evaluated the patient for right shoulder pain. On examination, there was tenderness present at the greater tuberosity, painful abduction, moderately limited range of motion and positive impingement sign. MRI of the shoulder was reviewed by and diagnoses given were rotator cuff strain or tear, labral tear and bicipital tenosynovitis. An arthroscopy of the right shoulder was planned.

Per discharge summary from clinic dated October 30, 2013, the patient had the last visit of therapy on October 30, 2013, and had completed eight visits, with modalities of exercises for progressive knee strengthening and flexibility, open and closed chain variety, including balance exercises. The patient improved range of motion, strength and functional activities. He had reached maximum rehab potential for pre-surgery and was discharged to a home exercise program.

On November 20, 2013, saw the patient for left ACL tear and noted some improvement. There was no improvement in the right shoulder. Examination of the left knee revealed mildly limited range of motion and positive Lachman's test. Right shoulder exam revealed tenderness at the greater tuberosity, painful abduction, moderately limited range of motion, positive empty cans test and positive impingement sign. He diagnosed ACL sprain/tear, rotator cuff strain/tear, labral tear and bicipital tenosynovitis. The patient was approved for surgery.

On December 18, 2013, saw the patient in follow-up for right shoulder and left knee. The patient stated his knee gave out on him but not as much as it did before therapy. Shoulder pain was worse. Acetaminophen with codeine was refilled.

On February 6, 2014, performed left knee arthroscopy with anterior cruciate ligament revision with tibialis anterior allograft, Tightrope fixation, interference screw distally and lateral meniscal root repair.

On February 17, 2014, recommended continuing the left knee brace, nonweightbearing status and initiating physical therapy.

On February 20, 2014, the patient underwent physical therapy initial evaluation status post knee repair and was recommended therapy two times a week for four weeks. From February 20, 2014, through March 20, 2014, the patient attended eight visits of therapy.

On March 17, 2014, noted the patient was much improved with regards to his left knee. Physical therapy was helpful. The patient now wanted to schedule right shoulder surgery. recommended continuing physical therapy.

Per March 20, 2014, physical therapy note, the patient had been seen for nine visits of therapy. He was recommended eight more visits.

From March 28, 2014, through April 23, 2014, the patient completed the ACL protocol with eight more visits.

Per April 11, 2014, therapy note, the patient had completed 13 visits between February 27, 2014, through April 11, 2014.

On April 14, 2014, noted the patient had good response to therapy for his knee.

Per discharge summary from dated April 23, 2014, the patient underwent 17 visits of therapy since the day of evaluation of February 20, 2014, status post left knee repair. The modalities utilized were ROM, stretching, gait training, proprioceptive re-education, pain management, neuromuscular re-education. He showed great steady progress in AROM, strength and function. He had reached maximum rehab potential and was discharged to home exercises.

On May 14, 2014, reported the patient walked in his gravel driveway and rolled his foot forward on a rock and partially hyperextended his knee. He recommended continuing home exercises for the knee.

On June 17, 2014, noted the patient reported a feeling of shooting pain in the posterior aspect of his knee. No more medications were required. Follow-up in one month was recommended.

On June 19, 2014, performed right shoulder arthroscopic repair of rotator cuff, massive tear including repair of the subscapularis and supraspinatus tendons.

On July 1, 2014, followed up with the patient after the right shoulder surgery. He noted on June 29, 2014, the patient felt a pop in his shoulder and palm and thumb

of his right hand had been numb since that time. The patient was asked to continue the use of sling.

On July 22, 2014, followed up with the patient for left knee. There were no new problems reported and pain was much improved.

On August 5, 2014, saw the patient for right shoulder and noted the patient still had numbness from the inside of the elbow through the entire hand. The patient had not yet started therapy for right shoulder. The patient was recommended further referral for electromyography/nerve conduction velocity (EMG/NCV) study. Physical therapy was ordered for the right shoulder.

From August 18, 2014, through September 11, 2014, the patient attended therapy for the right shoulder.

On August 22, 2014, saw the patient for right arm numbness and tingling and performed a needle myography. The assessment given was ACL sprain/tear, rotator cuff strain or tear, bicipital tenosynovitis and carpal tunnel syndrome. He noted Tinel's test was positive on the right at the wrist.

On September 2, 2014, followed with the patient for right shoulder. The patient was attending therapy and had noted improvement in his strength and range of motion.

Per physical therapy visit dated September 11, 2014, the patient reported he had lot of pain in his shoulder. It was noted he had a larger tear in the rotator cuff than originally and he would be scheduled for surgery soon.

On September 26, 2014, MRI of the right shoulder revealed rotator graft failure with full-thickness rotator cuff repair involving the supraspinatus, infraspinatus and subscapularis tendons. There was moderate osteoarthritis of the glenohumeral joint and the AC joint. There was large subacromial-subdeltoid bursitis.

On October 8, 2014, reviewed the MRI findings of the right shoulder. The exam findings included moderately limited right shoulder range of motion. The diagnosis was right rotator cuff tear.

On October 21, 2014, saw the patient for evaluation of the right shoulder pain. He reviewed the MRI findings and diagnosed rotator cuff sprain/tear, pain in the shoulder joint and impingement syndrome. Revision of the rotator cuff repair with subacromial decompression was recommended.

On January 14, 2015, performed right shoulder arthroscopic revision rotator cuff repair with revision bursectomy and decompression, removal of retained foreign bodies including previously placed FiberWire suture, fiber tape, and suture anchors with extensive debridement including release of scar tissue and an anterior interval slide to allow rotator cuff tendon reapproximation.

On January 16, 2015, the patient underwent physical therapy evaluation and was recommended therapy two times a week for 8-10 weeks.

On January 27, 2015, saw the patient postoperatively and noted pain at the surgery site. The patient was recommended activity modification, continuation of right shoulder sling and therapy program.

From February 6, 2015, through April 28, 2015, the patient attended 24 visits of therapy for the shoulder.

On February 24, 2015, noted the patient was doing well with regards to his shoulder and was in therapy. He recommended continuing therapy per protocol and a home exercise program.

On March 10, 2015, the therapist recommended physical therapy two times a week for 4-6 weeks.

On March 13, 2015, followed up with the patient for right shoulder. He continued the patient on activity modification and therapy.

On April 14, 2015, noted the patient was doing well and he complained of some weakness and mild pain with certain movements. The patient was attending therapy.

A PT order was written on April 14, 2015, for continued physical therapy one to two times a week for 12 weeks with general modalities to improve the strength.

Per physical therapy discharge summary dated April 30, 2015, the patient underwent 24 visits of therapy to the right shoulder since February 6, 2015.

On May 6, 2015, an adverse determination letter documented non-authorization for medical necessity for 12 sessions of physical therapy to the right shoulder with the following rationale, *"For the described medical situation, Official Disability Guidelines do support consideration of treatment in the form of physical therapy services in the postoperative interval. However, at the present time, medical necessity for this specific request is not established as there is no documentation of a recent physician evaluation to support a medical necessity for this specific request. Generally, the above noted reference would support an expectation [or an ability to perform non supervised rehabilitation regimen when an individual is this far removed from undergoing surgical intervention to an affected shoulder. With this documentation, medical necessity for this request is not established."*

Per adverse determination letter dated June 4, 2015, reconsideration for 12 sessions of physical therapy to right shoulder were non-authorized with the following rationale, *"During the peer conversation, it was indicated that he did not know how many visits were undertaken to date. There is mild stiffness and weakness and the patient was last seen on 04/14/15. In this case, the patient has had physical therapy with an improvement in function. There are minimal deficits*

on physical exam and there was a revision cuff repair in 01/2015. The number of prior visits is not provided and the patient should be able to transition to a home exercise program at this point. The request exceeds evidence-based guidelines. Therefore, the request for 12 sessions of physical therapy, right shoulder is neither medically necessary nor appropriate.”

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

The claimant is male having significant injury to the right shoulder with reinjury requiring a second surgery. He is showing functional gains and more is anticipated. Per ODG Appendix D “Documenting Exceptions to the Guidelines” that completion of the recommended level of post operative physical therapy with documented and specific objective functional improvement, but still has objective functional deficits, an additional course of physical rehabilitation to address the functional deficit is reasonable. It is my opinion based ODG this is an exception given the age and the complications to permit additional therapy and therefore the decision should be overturned.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES