

Vanguard MedReview, Inc.

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IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Post Surgery Physical Therapy

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

This reviewer 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]:

10/08/2014: MRI Right Shoulder. **Impression:** 1. At least severe high-grade partial and essentially full-thickness proximal biceps tendon tear with an edematous tendon stump crossing the humeral head and maintaining its superior labral attachment. The craniocaudal tendon gap measures at least _____ tendon sheath. 2. Superior labral tear extending posterior the biceps labral anchor with an adjacent 1.5 cm superior glenoid subchondral cyst. 3. Supraspinatus tendinosis with articular sided fraying/partial tearing at the humeral attachment. 4. Subscapularis tendinosis and interstitial partial tearing. 5. Mild spurring edema along the acromioclavicular joint. 6. Mild subacromial/subdeltoid bursal distention.

10/08/2014: MRI Upper Extremity non-joint w/o contrast. **Impression:** 1. High-grade proximal biceps tendon tearing which was better depicted on the dedicated shoulder MRI. There is increased tendon signal and intramuscular edema within the proximal biceps which is identified approximately 10 cm distal proximal, humeral, cortical margin. 2. Superior labral tear extending posterior the biceps labral anchor with an adjacent 1.5 cm superior glenoid subchondral cyst. 3.

Supraspinatus tendinosis with articular sided fraying/partial tearing at the humeral attachment. 4. Subscapularis tendinosis and interstitial partial tearing. 5. Mild spurring edema along the acromioclavicular joint. 6. Mild subacromial/subdeltoid bursal distention.

10/08/2014: Progress Note. **Subjective:** Patient reports having less pain today with a current level of 5-6/10 in the R shoulder. **Assessment:** Pt exhibits severe muscle guarding of R shoulder with moderate to severe ROM limitations. **Plan:** Patient will be seen 3x week x 4 weeks for evaluation and treatment of the R shoulder. Patient will be progressed with therapeutic activity and exercise intensity, modalities, neuro re-ed, and manual therapy, as tolerated, to achieve maximum rehabilitation outcome. Patient will receive progressive, ongoing, home program instructions to perform between visits to the clinic.

10/24/2014: Office Visit. **Subjective:** This patient is here for review of his right shoulder. He was injured at work on 7/5/14. He was lifting material weighing approximately 100 pounds out of the back of a truck. He felt a "pop". The next day he noted a quite a bit of bruising on his biceps and shoulder. He has no history of previous problems or injury with his shoulder. He now has pain with movement. He cannot lift nor do any activities overhead. He has noted repeated catching and popping. He has had six weeks of physical therapy which helped with his stiffness but otherwise did not provide the ability to return to normal overhead activity. He is taking ibuprofen on a regular basis. He has also had a prescription for tramadol. He is right-handed. He cannot sleep on his right shoulder. He has continued with most of his duties at work and has not had restrictions, but is limiting his own activities. MRI on 10/8/14 shows a severe high grade essentially full thickness proximal biceps tendon tear with an edematous tendon slump crossing the humeral head maintaining the superior labrum attachment. There is a gap in the tendon of at least 4-5cm. There is a superior labrum tear with a cyst. There is fraying and partial tearing at the subscapularis. There is mild spurring and edema at the acromioclavicular joint. He has had an MRI of the upper extremity on 10/8/14 with similar findings on this report. In particular it is documented that the biceps tendon is intact at the radial tuberosity. **Objective:** Physical Exam shows findings typical of a right long head biceps tendon rupture. There is the bulge in the biceps. He has recovered good motion in his elbow with some weakness. However, he does have pain with overhead movement with repeated catching as his arm is lifted overhead and rotated at the shoulder. There is palpable and audible popping. **Plan:** The patient is advised that he has a remaining stump of the biceps tendon inside his shoulder joint. He also has a tear of the labrum. His pathology is discussed in detail. He is advised to go ahead with right shoulder examination under anesthesia, arthroscopy, debridement of his biceps tendon and repair of his labrum tear. It will not be possible to repair the biceps tendon because of the nature of the tear and the length of time since injury. Risks, indications, and alternatives are discussed along the surgery itself and postoperative course. Prescription for pain medication of Tyleno#3 with 30 tablets and two refills after the proposed procedure. The patient has insisted on remaining at full duty at work without restrictions.

01/29/2015: Operative Report. **Postoperative Diagnosis:** 1. Right shoulder glenoid labrum tear and biceps tendon tear with remaining stump of biceps. **Operation:** Right shoulder examination under anesthesia, arthroscopy, and repair of glenoid labrum tear with debridement.

01/30/2015: Re-Evaluation and Plan of Care. **Subjective:** Patient chief complaint is R shoulder pain and stiffness. **Objective:** PROM Shoulder Flexion 60/180 Abduction 50/180, Right shoulder 2+/5 Right elbow 2+/5. Patient walks with a stiff, protected, R shoulder girdle with no R arm swing due to post op immobilizer. The R elbow is held in a position flexed at the elbow 90 degrees and close by their side. **Assessment:** Pt underwent a Labrum Repair 1/29/15 by . Patient reports pain in the R shoulder on a scale of 1-10, #8 w/ activity and #6 at rest. R Shoulder 1/5, Flexion 60/180, Abduction 50/180 **Plan:** Patient will be seen 3 x week x 4 weeks for evaluation and treatment of the R shoulder. Patient will be progressed with therapeutic activity and exercise intensity, modalities, _____ re-ed, and manual therapy as tolerated to achieve maximum rehabilitation outcome. Patient will receive progressive, ongoing, home program instructions to perform between visits to the clinic.

02/09/2015: Office Visit. **Subjective:** This patient is here for review of his right shoulder after surgery. **Objective:** Physical Exam shows wounds are benign. He moves his fingers well. **Plan:** The patient's sutures are removed. He will continue therapy at . He is on restrictions of no pushing/pulling, no climbing stairs, ladders, no reaching, no overhead, must wear immobilizer, no driving, must take prescription medications, desk work only.

02/19/2015: Progress Note. **Subjective:** Patient reports no change in pain level, still a 2/10 and that is only w/ toward endrange. Pt states he is experiencing more stiffness than pain. **Assessment:** Shoulder flexion= 145/180, abduction=140/180, extension, 50/50, internal rotation=65/70 and external rotation=90/90 w/ grip on R=66lbs and left=82lbs. All measurements are taken w/ PROM. Pt continues to wear arm sling but removes frequently to allow for stretching. **Plan:** Progress with plan of care as outlined in re-evaluation.

02/23/2015: Office Visit. **Subjective:** This patient is here for review of his right shoulder after surgery on 1/29/2015 for arthroscopy and repair of a glenoid labrum tear. A note from his therapy states that he has seven visits left approved on this series. His shoulder passive flexion is 145 degrees with passive abduction of 140 degrees. **Objective:** Physical examination shows his wounds are benign. He moves his fingers well. 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 . He may engage in strengthening and progress as tolerated. He is on work restriction of no pushing/pulling, no climbing stairs/ladders, no reaching, no overhead, must wear his immobilizer, no driving, must take prescription medications, may not perform any lifting/carrying, and desk work only.

03/09/2015: Office Visit. **Subjective:** This patient is here for review of his right shoulder. A note from therapy states that his flexion is 170 degrees with abduction

of 160 degrees. **Objective:** Physical examination shows his wounds are benign. He moves his fingers well. 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 . He may engage in strengthening and progress as tolerated. He is on work restriction of no pushing/pulling, no climbing stairs/ladders, no reaching, no overhead, must wear his immobilizer, no driving, must take prescription medications, may not perform any lifting/carrying, and desk work only.

04/06/2015: Office Visit. **Subjective:** This patient is here for review of his right shoulder. A note from his therapy is not available. The patient has reported that he had a designated doctor examination on 3/24/15. A recent physical therapy note states that his active shoulder flexion is 150 degrees with abduction of 140 degrees. **Objective:** Physical examination shows his wounds are benign. He moves his fingers well. HE can place his hand behind his head. He can touch his opposite shoulder. He can place his hand behind his back. Rom is as noted above. **Plan:** The patient will continue therapy at. He may continue to engage in strengthening and progress as tolerated. He has been advised that he does seem to be losing motion when comparing today's visit with his previous visit two weeks ago. The danger of a frozen shoulder/adhesive capsulitis is discussed in detail. Home exercises are emphasized.

04/09/2015: UR. **Rationale for Denial:** The patient is a male who was injured on xx/xx/xx when he picked up a box. He is diagnosed with right shoulder glenoid labrum tear and biceps tendon tear with remaining biceps stump. A request is made for 12 physical therapy visits for the right shoulder. Documented treatments included activity restrictions, medications, physical therapy, home exercise program, immobilization, and ice application. Right shoulder MRI dated 10/8/14 by demonstrates at least severe high-grade partial and essentially full-thickness proximal biceps tendon tear, superior labral tear with an adjacent superior glenoid subchondral cyst, supraspinatus tendinosis with articular-sided fraying/partial tearing at the humeral attachment, subscapularis tendinosis and interstitial partial tearing, mild spurring edema along the acromioclavicular joint, and mild subacromial//subdeltoid bursal distension. Right humerus MRI on the same dated showed high-grade proximal biceps tendon tearing. The patient underwent right shoulder examination under anesthesia, arthroscopy, and repair of glenoid labrum tear with debridement on 1/29/2015. He presented for initial postoperative PT evaluation on 1/30/15. Right shoulder AROM was 60 degrees on flexion and 50 degrees on abduction. Strength of the right shoulder and right elbow was 2+/5. The 3/5/15 PT reevaluation documented right shoulder AROM to 170 degrees on flexion, 160 degrees on abduction, the C7 level on external rotation, and the right posterior superior iliac spine on internal rotation. On 3/30/15, the patient felt a sharp pain in his posterior shoulder while he was helping lift a 40-50 pound PVC pipe overhead at work. He had increased shoulder pain with PROM over 150 degrees elevation, whereas he was previously able to raise his arm actively above 170 degrees without an increase in pain. As per 4/3/15 report, he had been seen for 23 visits since his surgery with fair progress towards his long-term goals. He was making slow but steady improvement in strength. He still lacked the

functional capacity to return to full duty. He has been working modified duty. Right shoulder AROM reached 150 degrees on flexion, 140 degrees on abduction, the "C0" level on external rotation, and to the right pocket on internal rotation. Right shoulder strength was 3-/5 and right elbow strength was 3/5. The patient was very guarded with raising his arm above shoulder level. Continued skilled physical therapy was recommended to address remaining deficits. Guidelines support up to 24 visits for management following labral repair. Although additional treatments in excess of the guideline's provisions are considered reasonable given the patients recent aggravation of pain with documented regression in AROM, there is no indication for 12 sessions at this time. Also, no more than four modalities/procedural units per visit are generally recommended to allow the PT visit to focus on those treatments where there is evidence of functional improvement and to limit the total length of each PT visit to 45-60 minutes. Given these issues, the medical necessity of this request is not fully substantiated.

05/04/2015: Office Visit. **Subjective:** The patient is here for review of his right shoulder. A note from his therapy is not available. The patient has reported that he had a designated doctor examination on 3/24/15. A recent physical therapy note is not available as the patient has not been approved for more therapy. This office has been notified that an initial application for more therapy was denied and an appeal has been submitted. **Objective:** Physical examination shows his wounds are benign. He moves his fingers well. He can place his hand behind his head. He can touch his opposite shoulder. He can place his hand behind his back. ROM is better than on his previous visit. **Plan:** The patient will continue therapy at if more can be approved. He may continue to engage in strengthening and progress as tolerated. He has been advised that he needs to be aggressive about not losing ROM. Refill of his ibuprofen 800 mg.

05/08/2015: UR. **Rationale for Denial:** The patient is a male who was injured on xx/xx/xx when he picked up a box. He is currently diagnosed with right shoulder glenoid labrum tear and biceps tendon tear with remaining biceps stump. An appeal request was made for 12 PT to the right shoulder. The previous request was denied because although additional treatments in excess of the guidelines' provisions are considered reasonable given the patient's recent aggravation of pain with documented regression in AROM, there is no indication for 12 sessions at this time. Moreover, no more than four modalities/procedural units per visit are generally recommended to allow the PT visit to focus on those treatments where there is evidence of functional improvement and to limit the total length of each PT visit to 45-60 minutes. Documented treatments included activity restrictions, medications, physical therapy, home exercise program, immobilization, and ice application. Right shoulder MRI dated 10/8/14 by (no official report) demonstrated at least severe high-grade partial and essentially full-thickness proximal biceps tendon tear, superior labral tear with an adjacent superior glenoid subchondral cyst, supraspinatus tendinosis with articular-sided fraying/partial tearing at the humeral attachment, subscapularis tendinosis and interstitial partial tearing, mild spurring edema along the acromioclavicular joint, and mild subacromial//subdeltoid bursal distension. Right humerus MRI on the same dated showed high-grade proximal biceps tendon tearing. The patient underwent right

shoulder examination under anesthesia, arthroscopy, and repair of glenoid labrum tear with debridement on 1/29/2015. He presented for initial postoperative PT evaluation on 1/30/15. Right shoulder AROM was 60 degrees on flexion and 50 degrees on abduction. Strength of the right shoulder and right elbow was 2+/5. The 3/5/15 PT reevaluation documented right shoulder AROM to 170 degrees on flexion, 160 degrees on abduction, the C7 level on external rotation, and the right posterior superior iliac spine on internal rotation. According to the 3/31/15 report, the patient felt a sharp pain in his posterior shoulder when he tried to lift a 40-50 pound PVC pipe overhead at work. He had increased shoulder pain with PROM over 150 degrees elevation, whereas he was previously able to raise his arm actively above 170 degrees without an increase in pain. As per 4/3/15 report, he had been seen for 23 visits since his surgery with fair progress towards his long-term goals. He was making slow but steady improvement in strength. He still lacked the functional capacity to return to full duty. He has been working modified duty. Right shoulder AROM reached 150 degrees on flexion, 140 degrees on abduction, the "C0" level on external rotation, and to the right pocket on internal rotation. Right shoulder strength was 3-/5 and right elbow strength was 3/5. The patient was very guarded with raising his arm above shoulder level. Continued skilled physical therapy was recommended to address remaining deficits. Updated documentation included UR determination dated 4/9/15, and visit note dated 4/6/15. According to the report dated 4/6/15 by , the patient has reported that he had a designated doctor exam on 3/24/15. Objective findings noted his wounds are benign. He moves his fingers well and can place his hand behind his head. He can touch his opposite shoulder. He can place his hand behind his back. HEP was emphasized and he was recommended to continue Physical Therapy for strengthening. However, the prior reasons for non-certification are still unaddressed. While additional treatments in excess of the guidelines' provisions are considered reasonable given the patient's recent aggravation of pain with documented regression in AROM, there is no indication for 12 sessions at this time. Moreover, the number of specified CPT codes exceeds the average four modalities/procedural units per visit generally recommended by the guidelines. In agreement with prior determination, the medical necessity of this request is undetermined at this time.

05/12/2015: Request for reconsideration. This letter is seeking 12 visits of additional therapy given the patient's recent aggravation of pain with documented regression of AROM. still shows a lack in functional capacity to return to full duty. This has been documented in both medical and therapy notes. sessions have been 60 minutes with no more than 4 total units per session. Your denial letter even states that additional treatments are considered reasonable due to the above mentioned increase in pain and decrease in AROM. The purpose of the requested sessions would be to gain any lost AROM and to build needed functional capacity.

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

The previous adverse determinations are upheld. I agree with the denial of more physical therapy as recommended by and . He has had 24 physical therapy sessions as recommended by ODG guidelines for surgical care of a Labral tear, and has achieved good range of motion. He should respond well to an aggressive home exercise program. For these reasons, Additional Post Surgery Physical Therapy is not medically necessary.

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 week

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)**