IRO REVIEWER REPORT – WC

DATE OF REVIEW: April 27, 2018
IRO CASE #: XXXXXX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
14 Sessions of Physical Therapy on left shoulder

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Board Certified in Orthopedic Surgery

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

☒Upheld (Agree)

☐Overturned (Disagree)

☐Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute:

- 14 Sessions of Physical Therapy on left shoulder – Upheld.

PATIENT CLINICAL HISTORY:
The claimant is currently XX. On XXXX, the claimant completed a report of injury noting that XX, the claimant injured the left shoulder/arm.

XX filed on XXXX disputed all medial and indemnity benefits related to the findings on the MRI of the cervical spine. The claimant had not established a causal relationship between the conditions and the XXXX incident and there was no objective medical evidence to support that these conditions were a direct result of the compensable injury.

XX filed on XXXX disputed entitlement of medical and indemnity benefits related to left carpal tunnel syndrome.

XX saw the claimant on XXXX for arm and back pain, left sided, onset today while restraining. The claimant was XX and weighed XX, BMI of XX. The claimant stated XX

was in restrains about XX and strained the left shoulder, XX left shoulder and had pain in the neck and left shoulder and back of the left arm with tingling in the hand. Dx: Strain of muscle of left shoulder. Prescribed medications and RTW light duty.

X-ray of the left shoulder and humerus dated XXXX were negative.

XX saw the claimant on XXXX for left shoulder sprain/strain and neck pain while XX the left arm. PMH positive for anemia, anxiety disorder, ulcer disease. XX and XX ordered. MRI of neck ordered. Dx: Cervical myofascial strain, cervical radiculitis, left shoulder strain, thoracic myofascial strain, contusion of left upper arm.

MRI of the cervical spine dated XXXX read by XX showed disc disease at C5-6 and C6-7 causing only mild canal narrowing; high grade left sided C7 foraminal stenosis at C6-7 level, due mostly to uncovertebral joint hypertrophy.

On XXXX, XX saw the claimant and reviewed the cervical MRI and reported that the MRI findings were consistent with left C7 nerve root impingement which was the likely source of neck and left shoulder pain and radiating pain. PT for the neck and shoulder ordered and consult with XX ordered to consider an ESI. RTW light duty. Current pain was a 2.

XX performed an initial eval. on XXXX. Total pain score was 76%. Total disability score was 81%; total Spadi score was 79%. XX approved XX PT sessions for the neck and left shoulder. There was a discharge summary on XXXX noting claimant had attended XX treatments. Claimant had slightly better cervical ROM, but pain and shoulder were still the same. Discharged from therapy due to no/minimal change and claimant awaiting surgery.

MRI of the left shoulder dated XXXX read by XX showed supraspinatus and infraspinatus tendinosis without tear defect; circumferential free edge labral truncation with undersurface tearing of bicipital labral anchor and superior labrum; minimal posterior glenoid dysplasia; moderate AC joint osteoarthritis.

XX saw the claimant on XXXX for left shoulder new problem. The claimant c/o continued pain and catching in the shoulder. The claimant was right hand dominant and had been through PT with worsening. The claimant had occasional numbness and tingling and that had not been problematic. XX had noticed loss of shoulder motion. Exam noted positive Hawkins, Speed, O'Brien, and tenderness of long head of biceps tendon. Dx: Superior glenoid labrum lesion of left shoulder; bicipital tendinitis, bursitis, adhesive capsulitis of left shoulder. Surgery recommended.

On XXXX, XX saw the claimant for cervical and left arm pain. PMH positive for stomach ulcers, anxiety, depression and headaches. Pain was 4. To 6 most days. Exam showed strength was 5/5, Spurling was positive on the left. C6-7 facet pain to palpation was noted; reflexes were 2+/4, MRI showed C6-7 bulge with left foraminal narrowing. Dx: Sprain of joints and ligaments of neck; neck sprain; cervical disc disorder at C6-7 with radiculopathy. ESI ordered.

There was an initial PT Eval. @ XX on XXXX for left shoulder. The claimant was told XX would require surgery but had to go through therapy first. The claimant said XX required assistance from XX with dressing and XX assisted XX with house chores. The claimant said XX did drive and shop but not much use of the LUE. Active ROM of left shoulder

flexion was 40, extension to 20, abduction to 40, horizontal adduction to 5, IR to 50 and ER to 70. Total pain score was 98%, disability score 94%, SPADI score was 95%. XX approved XX PT sessions for left shoulder SLAP tear. There was a discharge summary dated XXXX having completed XX treatments, was scheduled for surgery on XXXX. Final ROM active of left shoulder was flexion to 50, extension to 20, abduction to 40, horizontal adduction to 5, IR to 50 and ER to 70. Pain score was 90%, disability score was 85%, SPAID score was 87%.

EMG/NC dated XXXX from XX showed findings most consistent with mild left CTS.

On XXXX, XX performed left shoulder arthroscopic biceps tenodesis. Postop dx: Left shoulder SLAP tear with unstable biceps insertion; very small/mild supraspinatus undersurface tear.

XX performed initial eval. on XXXX. This noted the claimant was medically separated from her position on XXXX. Pain was 3 at rest and 10 with activity. Pain score, disability score and SPADI score were all 100%. Passive left shoulder ROM was flexion to 125, abduction to 68, IR to 60 and ER to 26. Manual therapy/PROM and modalities ordered. Plan was to incorporate AAROM/Active ROM on XXXX. XX approved XX PT sessions for SLAP lesion of left shoulder. PT began on XXXX.

On XXXX, XX saw the claimant who was in XX sling and stated the pain was a little better. PT was just started due to w/c authorization and only had some soreness after exercises. Exam showed typical postop findings of the usual tenderness and ROM (not specified). Dx: Superior glenoid labrum lesion of left shoulder, s/p tenodesis; bicipital tendinitis, bursitis, adhesive capsulitis of left shoulder. XX reported that the claimant seemed to be off to a slow start partially because XX had just started PT and was well over XX out. XX reported that it took a while for w/c to approve therapy, but XX now had been to XX therapy sessions and hopefully could get back on track with recovery. Claimant to continue the sling for XX but then may ease out as tolerated. The claimant needed to be very diligent with therapy and would f/u with XX in XX for re-eval. to insure XX was going in the right direction. Claimant to be kept off work though had already ben separated medically from XX position.

On XXXX, therapist noted claimant had some soreness from added exercises as they had proceeded with AAROM exercises per physician referral. On XXXX, claimant reported that pain calmed down after a couple of hours post therapy. Therapy notes continued.

XX Re-Eval was dated XXXX. The claimant reported some progress since starting therapy, had continued to wear sling and perform home exercises and wished to continue therapy for further gains. Pain was 2 at rest and 9 with activity. Passive left shoulder flexion was 135, abduction to 90, IR to 60 and ER to 32. Active flexion was 40 and abduction to 20. Goals partially met for flexion and abduction, not met for IR and ER. Pain score was 100%, disability score was 94%, SPAID score was 96%. Claimant had received manual therapy/PROM and modalities for reduction of pain and improved tolerance to exercises. Plan to incorporate light strengthening on XXXX, XX postop. On XXXX, claimant had decreased wearing sling at home but still wore it around town. On XXXX, claimant reported pain was 1 today and was able to go most of the day at home without the brace. Pain was 2 on XXXX and missed last visit due to illness. Claimant reported more pain and stiffness today. On XXXX, claimant reported low pain

today, had a f/u with physician today. Plan was for re-eval next session and request more visits XX. Would continue with AAROM, start light strengthening on XXXX.

XX saw the claimant for f/u on XXXX who was improved. The claimant still had some pain issues but overall had been seeing improvements. Exam of left shoulder noted typical postop findings, the usual tenderness and ROM. Rom was moderately decreased but improved (not specifics). Strength not tested today-improved (??). No gross laxity. Claimant was progressing very well and was encouraged to continue exercises/therapy. RTW light duty if available.

XX Re-Eval. was dated XXXX. The claimant reported XX had seen benefit from therapy so far and wished to continue for further gains. Request XX as XX had been receiving therapy XX. Pain at rest was 1 and with activity was 7. Current active flexion on left was 90 and abduction was 52. Passive left ROM was 138, abduction to 120, IR to 50 and ER to 40. Plan was to test strength/AAROM at XX post-surgery. Pain score was 86%, disability score was 92%, SPADI score was 90%. Therapist noted claimant presentation was stable with severe impairments in ROM and strength of LUE due to recent surgery, limiting ability to perform ADL which required any LUE movement. Claimant had received manual therapy/PROM and modalities for reduction of pain and improved tolerance to exercises. Plan was to incorporate light strengthening on XXXX, XX postop. The plan was to test strength and AAROM at XX post-surgery. Grip strength was documented at 69 on the right and 22 on the left. (no other strength documented). The claimant had responded well to interventions noted as represented by outcome measures/grip strength/active ROM/SPADI. The claimant had been given a home exercise program. (had undergone XX postoperative PT visits through this date per records available).

XX on XXXX denied 14 PT sessions.

XX saw the claimant for f/u on XXXX for the neck and shoulder. The neck pain was over the left trapezius area and not over the spine rated at a 2. The claimant was currently only taking 1 of the XX or XX about once a week. The claimant reported that starting the XX had helped and XX was continuing to take XX for muscle spasms. XX was not working. The claimant was seen by XX on XXXX who released the claimant from the sling and was pending approval for additional therapy. The claimant had been working on ROM but had not yet begun strengthening. Exam of cervical spine noted tenderness to palpation greatest on left trapezius with spasms; left shoulder exam showed tenderness, positive for pain; abnormal strength and tone, abnormal ROM, crepitus, tenderness along subacromial bursa, upper trapezius muscle, abnormal scapulohumeral rhythm, muscle testing showed abnormal strength and tone. Left shoulder AROM IR was 40, ER to 30, extension to 15, flexion to 80; glenohumeral abduction to 45, adduction to 20. Claimant to continue off work as no sedentary work was available and the claimant must protect the left shoulder from any reinjury. The claimant was proceeding with PT, progressing slower than average, still with significant lack of ROM and just beginning the strengthening phase. The claimant needed considerable rehab at this time. The claimant was no longer using XX and continue intermittent XX with XX. If possible, XX goal was to resume normal job duties.

XX on XXXX denied additional 14 PT sessions for the left shoulder. ODG would not support a medical necessity for this specific request. ODG would support treatment in the form of supervised rehab to maximize functional recovery, though the requested

amount of treatment would exceed what would be supported per criteria. An official operative report was not available for review. Medical document dated XXXX indicated that prior treatment included XX PT sessions. Subjectively pain was a 1. Objectively, there was an ability to actively flex to 90 and abduct to 52.

XX saw the claimant on XXXX for f/u on XXXX. The pain was in left shoulder to arm, described as moderate, worsening, dull and burning, mild and severe (??), with decreased ROM, weakness, pain with lifting, numbness and tingling. The claimant still had weakness in strength and was only lifting 2-pound weights in PT. The claimant had limited ROM with aching pain up and down the arm. Exam of the left shoulder noted typical postop findings, the usual tenderness and ROM; ROM moderately decreased with 90 degrees of passive flexion, 85 of passive abduction very limited at L1, ER. There was "brace" (? Unknown meaning) and could only active flex and abduction about 45. Strength and tone were not tested today. Sensation intact. XX reported the claimant had quite a bit of stiffness and had some adhesive capsulitis issues which had limited her progressing with therapy. XX noted that the claimant could only passively forward flex to 90 and abduct to 85 and could only get to about 45 degrees of flexion and abduction actively without severe pain. XX noted that XX obviously needed quite a bit more therapy. Recommend formal therapy and get XX back on track with recovery. The claimant was pleased with this plan and would be diligent with therapy both formally and on XX own.

XX on XXXX denied 14 additional PT sessions after reconsideration. The additional documentation provided for this included a XXXX note and an ortho. eval. on XXXX. Peer reviewed guidelines support 24 postop visits of PT over 14 weeks for postsurgical treatment of labral repair/SLAP lesions, 24 over 14 weeks for postsurgical treatment of adhesive capsulitis and 16 over a period of 8 weeks for medical treatment of adhesive capsulitis. The requested 14 additional therapy to the left shoulder was in excess of guidelines. The claimant had completed XX PT visits. An additional 7 PT visits may be warranted as the claimant still had ROM deficits and was reported to be making progress. However, without being able to conduct a peer to peer with the requesting physician or someone on their behalf in order for them to approve a partial certification, the request was non-certified in whole.

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

The XX had XX formal physical therapy sessions prior to surgery and has undergone XX formal physical therapy sessions after the surgery. The surgery that was performed on XXXX was a left shoulder arthroscopic biceps tenodesis.

Review of the postoperative formal physical therapy notes have documented ongoing high levels of subjective pain and disability scores in the shoulder, though the reported pain levels are low. The postoperative therapy notes have identified an increase in passive range of motion and active motion, with the most recent evaluation noting active flexion to 90 and abduction to 52. The claimant is right handed, and the surgery was performed on the non-dominant side, the left shoulder. The Official Disability Guidelines recommends up to 24 postoperative visits over 14 weeks prior to transitioning to a home exercise program. The claimant was approved for XX postoperative visits after the physical therapy evaluation dated XXXX and has completed those visits. While the ODG would support additional formal physical therapy of 7 to 8 visits before a re-

evaluation, medical necessity is not established for the requested additional 14 formal physical therapy visits.

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

- ☒ **MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

- ☒ **ODG - OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**