Envoy Medical Systems, LP

1726 Cricket Hollow
Austin, Texas 78758

PH. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #

DATE OF REVIEW: 7/20/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Occupational Therapy Services: Therapeutic Exercise Joint Mobilization – 12 visits (4 approved (5/17/07 – 5/31/07)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
M.D. Board Certified in Physical Medicine and Rehabilitation

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

XUpheld (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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Table of Disputed Services
Denial Letter from Insurance Co.
MRI of the left shoulder – 11/06
Medical Records – M.D. 12/06 – 5/07
Occupational Therapy Notes – xx/xx – 6/07

PATIENT CLINICAL HISTORY [SUMMARY]:
This case involves a female who injured her shoulder on xx/xx/xx. She works as a bindery operator. She tripped and fell forward onto her left shoulder. She had an MRI on 11/17/06 revealing a torn supraspinatus tendon. She was sent to an Orthopedic Surgeon for an evaluation in December of 2006. She underwent rotator cuff repair in January of 2007. She started postoperative physical therapy in March of 2007 working only on passive and gentle active assisted range of motion. She was released to begin strengthening exercises in May of 2007. Eight sessions of physical therapy have been requested to work on improving strength and has been denied by the carrier

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

I agree with the benefit companies' decision to deny the request of 8 session of physical therapy. The patient has progressed well with her postoperative physical therapy. Her range of motion has improved greatly. She measured at 120 degrees of flexion, 125 degrees abduction, 65 degrees of internal rotation and 55 degrees of external rotation. She denies any pain and takes no medication for pain. She reportedly is independent in her home exercise program including theraband strengthening. The records submitted for this review have not demonstrated the need for additional physical therapy.

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**

X **MEDICAL JUDGMENT, 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)