

**C-IRO, Inc.**  
**An Independent Review Organization**  
7301 Ranch Rd. 620 N, Suite 155-199  
Austin, TX 78726

**DATE OF REVIEW: OCTOBER 9, 2007**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Occupational Therapy 3 times a week for 4 weeks, right shoulder

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

*Doctor of Medicine (M.D.)  
Board Certified in Orthopaedic 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.

*The reviewer has determined that medical necessity exists for 2 additional occupational therapy visits, not the 12 that were requested. Therefore, the reviewer is partially overturning the decision.*

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letters, 9/5/07, 9/17/07  
ODG Physical Therapy Guidelines  
Right Shoulder MRI, 6/6/07  
Dr. Operative Report  
Notes, 9/24/07, 9/5/07, 8/30/07, 8/27/07, 7/30/07, 7/11/07, 7/2/07, 6/18/07,  
6/11/07, 5/25/07, 5/8/07, 4/13/07, 3/15/07, 1/12/07, 12/22/06

Medicine Centers, 9/17/07, 9/24/07, 7/30/07, 12/22/06, 12/29/06, 6/14/07, 6/21/07, 8/27/07, 8/30/07, 8/10/07

## **PATIENT CLINICAL HISTORY [SUMMARY]:**

*The injured employee underwent arthroscopic shoulder debridement, biceps tenodesis and open rotator cuff repair. He received 23 post-op therapy visits and 12 more have been requested.*

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

*Although the ODG guidelines recommend 24 postoperative visits for this type of shoulder surgery (see below), the reviewer believes it would be reasonable to authorize 2 more visits.*

*The reviewer considered the ODG guidelines in the determination of this case, but as discussed above, the patient's circumstances were such that this reviewer determined it was medically necessary to diverge from the guidelines.*

*Therefore, the reviewer finds that medical necessity exists for 2 additional occupational therapy visits, and not the 12 that were requested. Therefore, the reviewer is partially overturning the decision.*

### **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](#).

#### **Adhesive capsulitis:**

16 visits over 8 weeks

#### **Rotator cuff syndrome/Impingement syndrome:**

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

#### **Dislocation of shoulder:**

12 visits over 12 weeks

#### **Acromioclavicular joint dislocation:**

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

#### **Sprains and strains of shoulder and upper arm:**

9 visits over 8 weeks

#### **Sprained rotator cuff:**

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment: 24 visits over 14 weeks

#### **Brachial plexus lesions:**

Medical treatment: 14 visits over 6 weeks

Post-surgical treatment: 20 visits over 10 weeks

#### **Fracture of humerus**

18 visits over 12 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: OKU SHOULDER AND ELBOW)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)