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DATE OF REVIEW: JULY 11, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

12 Sessions Physical Therapy (3 x wk x 4 wk)

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

Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

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

Upheld (Agree)

X 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.

PATIENT CLINICAL HISTORY [SUMMARY]:

This case involves a xx-year-old male who works as a xxxx. He was assaulted one morning while as work by an inmate, sustaining multiple blows to the head and face. He was taken to the local emergency room where a head CT scan revealed a subarachnoid hemorrhage and subdural hematoma. A CT of the face did not show any fractures. He was admitted for observation overnight and discharged the following day. After discharge he reported shoulder pain. The evaluation included an attempted arthrogram of the shoulder, which was not successful. He followed up with Dr. on 3/31/08. A repeat MR arthrogram of the shoulder on 4/11/08 revealed a rotator cuff tear. He underwent left rotator cuff repair and acromioplasty by Dr. on 4/22/08. He underwent 15 postoperative physical therapy treatments. Twelve more sessions have been requested and denied.

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

I disagree with the benefit company's decision to deny the requested 12 sessions of physical therapy. The patient has rotator cuff surgery followed by 15 postoperative sessions of physical therapy. Per ODG Guidelines, 24 visits are recommended. Therefore, additional sessions of PT would be reasonable and medically necessary. At that time the patient should be independent in his home exercise program and able to progress his strength and range of motion.

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)**