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## Notice of Independent Review Decision

**DATE OF REVIEW:** 07/24/08

**IRO CASE #:**

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

Outpatient physical therapy for right shoulder 3x wk / 4 weeks

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

Licensed 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.

Outpatient physical therapy for right shoulder 3x wk / 4 weeks - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Examination evaluation, , M.D., 09/24/07, 10/15/07, 10/29/07, 11/15/07, 01/17/08, 01/31/08, 02/11/08, 02/18/08, 03/03/08, 03/17/08, 03/31/08, 04/24/08, 05/22/08, 06/19/08, 06/26/08

- MRI of the lumbar spine, , M.D., 11/12/07
- Notice of disputed issue(s) and refusal to pay benefits, 11/21/07, 01/09/08, 01/14/08
- MRI of the right shoulder, Dr. , 12/05/07
- DWC-73, Dr. , 12/06/07, 12/13/07, 01/31/08, 03/17/08, 04/24/08, 05/22/08, 06/19/08
- Physical therapy notes, , P.T., 12/07/07, 12/11/07, 02/19/08, 02/21/08, 02/25/08, 02/27/08, 02/29/08, 03/04/08, 03/10/08, 03/12/08, 03/18/08, 03/20/08, 03/21/08, 03/24/08, 03/25/08, 03/27/08, 04/01/08, 04/02/08, 04/03/08, 04/07/08, 04/09/08, 04/21/08, 04/22/08, 04/23/08, 04/29/08, 05/01/08, 05/05/08, 05/06/08, 05/08/08, 05/12/08, 05/13/08, 05/15/08, 05/19/08, 05/20/08, 05/23/08, 06/02/08, 06/03/08, 06/05/08, 06/09/08, 06/10/08, 06/12/08
- Medical record review, , 12/08/07
- Right Shoulder Diagnostic Arthroscopy/Primary Right Shoulder Arthroscopic Rotator Cuff Repair/Arthroscopic Right Shoulder Subacromial Decompression and Acromioplasty/Arthroscopic Right Distal Clavicle Resection, Dr. , 02/07/08
- Physical therapy notes, , P.T., 03/06/08
- Physical therapy notes, , P.T., 03/14/08
- Pre-authorization request form, 04/08/08, 05/12/08, 06/04/08, 06/23/08
- Therapy referral, and , 04/24/08
- Notice of utilization review decision, 04/24/08, 05/15/08
- Staffing conference and weekly progress report, , LAT, 05/09/08
- Physical therapy notes, , P.T., 05/27/08
- Adverse determination, 06/10/08, 06/14/08, 06/24/08, 07/01/08
- Notice of assignment of IRO, 07/09/08
- Therapy referral, and (no date)
- The ODG Guidelines were provided by the carrier or the URA.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

The patient sustained an injury on xx/xx/xx. He complained of headaches, pain on his right shoulder and arm, and pain in his low back radiating to his hip as his primary pain. The patient has undergone multiple MRI's, surgery, and physical therapy.

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

At this point, the patient is five and a half months post arthroscopic rotator cuff tear, with subacromial decompression and Munford procedure. The physician's postoperative notes and the physical therapy notes by his therapist plainly show

that this patient has excellent range of motion and excellent strength. He has no evidence of any postoperative complications that would warrant further physical therapy modalities. Also, he was counseled and educated regarding a home exercise program and there is no reason why he cannot rehabilitate his shoulder on his own at home.

When people have arthroscopic shoulder surgery after an appropriate period of time, they can begin physical therapy modalities, which this patient did. After they have matriculated through a course of physical therapy and reached certain levels of range of motion and muscle strength, they can be progressed to more aggressive-intensive physical therapy modalities and be returned to work, according to their physical exam and improvement with physical therapy. This patient has shown slow, but steady progression of his range of motion and his strength. He has no evidence of any restricted range of motion, weakness, or other dysfunction of his right shoulder that would necessitate further supervised physical therapy modalities.

**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)**