

True Decisions Inc.

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: July 9, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

9 Additional Sessions Physical Therapy

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

Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines

Denial Letters 6/11/08 and 6/24/08

Records from Rehab Associates: 4/24/08, 5/6/08, 6/5/08, and 6/4/08

MRI 4/30/08

CT Scan 4/24/08

Records 1/31/08 doctor unknown

Transportation No Date

Records from Rehab Associates 4/8/08 thru 6/24/08

PATIENT CLINICAL HISTORY [SUMMARY]:

Xx year old xx reportedly was injured on xx/xx/xx in xxxx when he felt a pop in his shoulder. A fracture or dislocation was considered. He was seen and treated in xxxxx. His CT scan did not show any fracture. The MRI on 4/30/08 described a tendinopathy and

possible incomplete tear in the articular surface of the supraspinatus tendon plus a subchondral cyst. He received 21 sessions of PT. He was improving and had a home exercise program. The additional notes from the physical therapist reported increased popping and a need for a corticosteroid injection for ongoing pain and popping.

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

The records show improvement and then some deterioration. The diagnosis is that of a tendinopathy and the acromion congenital curve. The latter may be contributing to the popping.

The ODG has several physical therapy guidelines for shoulder problems based upon diagnosis. These work on a “fading” frequency of visits. His clinical symptoms suggest a combination of rotator cuff syndrome and shoulder sprain rather than a dislocation. Although they all differ slightly, they average 1, or possibly 2, therapy sessions a week for 10-12 sessions. These are too combined with a self directed home program. He received 21 sessions to date. There is no justification for the larger number of therapy treatments based upon the information provided.

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](#).

Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Dislocation of shoulder (ICD9 831):

Medical treatment: 12 visits over 12 weeks

Post-surgical treatment (Bankart): 24 visits over 14 weeks

Acromioclavicular joint dislocation (ICD9 831.04):

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

Sprained shoulder; rotator cuff (ICD9 840; 840.4):

Medical treatment: 10 visits over 8 weeks

Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 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)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**