

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

DATE OF REVIEW: 06/11/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Physical therapy 2 x a week for 4 weeks

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the physical therapy 2 x a week for 4 weeks is medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Prescription for physical therapy from Dr. – 04/28/08
- Office visit notes for Dr. – 04/24/08 to 05/08/08
- Report of MRI of the right shoulder – 01/16/08

- Operative Note – 02/08/08
- Notice to Utilization Review Agent of Assignment of IRO – 05/22/08
- Request for precertification for physical therapy – 05/07/08
- Notice of Utilization Review findings – 05/06/08, 05/14/08
- Information for requesting a review by an IRO – 05/12/08
- Notice to TMF Institute of Case Assignment – 05/22/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx when he was pushing a gate open and injured his right shoulder. An MRI of the right shoulder performed on 01/16/08 revealed a full-thickness tear of the leading edge of the supraspinatus with slight retraction and associated tendinosis. The patient underwent an arthroscopy of the right shoulder with biceps tenodesis, subacromial decompression and min-open rotator cuff repair. The patient was treated with physical therapy post-operatively.

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

This patient underwent an extensive shoulder surgery on 02/08/08. Physical therapy following a rotator cuff repair and biceps tenodesis is always required. The “Official Disability Guidelines” recommendations of 24 settings of physical therapy are just guidelines/recommendations. If continuous physical therapy advances the recovery of the patient, then further therapy is indicated.

**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)