



Southwestern Forensic
Associates, Inc.

DATE OF REVIEW: 10/21/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Physical therapy postoperative right shoulder arthroscopy

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:

M.D., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients with significant shoulder problems, shoulder surgery, and the need for physical therapy

REVIEW OUTCOME:

“Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED FOR REVIEW:

1. forms
2. referral forms
3. Denial letters, 09/16/08 and 09/25/08
4. Requestor records
5. Radiology requests
6. Anesthesia records, 06/20/08
7. Operative report, 06/20/08
8. Clinical notes, 04/13/08, 09/09/08, 07/01/08, and 05/02/08
9. Emergency room record, date not clear
10. Memos related to denial letters
11. Phone records, 06/06/08 and 05/06/08
12. MRI scan, right shoulder, 05/02/08
13. URA records
14. Physical therapy records, 09/08/08, 08/06/08, 07/11/08
15. Physical therapy prescription, 06/20/08

INJURED EMPLOYEE CLINICAL HISTORY (Summary):

This xx-year-old male presents with a long history of right shoulder problems. He underwent a right shoulder surgery in 1989 for rotator cuff tear including a subacromial decompression. He subsequently developed further right shoulder symptoms. He underwent an arthroscopy on 06/20/08 at which time a rotator cuff repair was performed with repeat subacromial decompression. Postoperatively he has been provided with 24 sessions of physical therapy. Additional physical therapy has been requested and denied.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

It would appear that the prior denial of additional physical therapy has been appropriately denied. The patient has been provided with the standard postoperative physical therapy as recommended by the ODG, 2008. Additional physical therapy does not appear to be appropriate in that his symptoms have not been beneficially affected by his full course of postoperative physical therapy.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:

(Check any of the following that were used in the course of your review.)

- 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
- Mercy Center Consensus Conference Guidelines.
- Milliman Care Guidelines.
- ODG-Official Disability Guidelines & Treatment Guidelines, 2008, Shoulder Chapter, Physical Therapy passage.
- Pressley Reed, The Medical Disability Advisor.
- Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
- Texas TACADA Guidelines.
- TMF Screening Criteria Manual.
- Peer reviewed national accepted medical literature (provide a description).
- Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)