

# C-IRO Inc.

An Independent Review Organization  
7301 RANCH RD 620 N, STE 155-199B  
Austin, TX 78726  
Phone: (512) 772-4390  
Fax: (512) 519-7098  
Email: resolutions.manager@ciro-site.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Apr/10/2009

**IRO CASE #:**

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

3x4 PT: 97110, 97014, 97010(G0283 PNR) Rt Shoulder 3/2/09-4/10/09 Quantity 12

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

MD, Board Certified in Physical Medicine and Rehabilitation  
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**

ODG Guidelines and Treatment Guidelines  
Adverse Determination Letters, 3/11/09, 3/2/09  
Orthopedic Surgery Group, 3/3/09, 2/20/09, 2/18/09

**PATIENT CLINICAL HISTORY SUMMARY**

This is a woman who injured her shoulder on xx/xx/xx. She underwent an open rotator cuff repair per Dr. (2/20/09). Dr. wrote she had an open rotator cuff repair with a decompression acromioplasty. He noted in that examination that she was months postop and still had stiffness. The therapist noted on 2/19/09 that the patient was having cramps in the deltoid and biceps, but continued to work with them. She has reportedly had 24 sessions of therapy.

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

This patient has had 24 sessions of physical therapy. The ODG authorizes 30 sessions following an open procedure and 40 for a complete rotator rupture. The request is for 12 additional sessions. The treatments include Therapeutic exercises (97110), Electrical stimulation (97014) and hot packs (97010). The guidelines would permit an additional 6 physical therapy sessions for this patient. The request does exceed the recommended number of sessions in the guidelines, however in this particular case the patient has not received the full 30 sessions recommended, and the reviewer is not permitted to partially overturn this request. Therefore, the reviewer finds reason to approve an additional 12

sessions for this patient. The reviewer finds that medical necessity exists for 3x4 PT: 97110, 97014, 97010(G0283 PNR) Rt Shoulder 3/2/09-4/10/09 Quantity 12.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)