

SENT VIA EMAIL OR FAX ON
Mar/05/2009

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Feb/25/2009

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

PT left shoulder 5 X 2

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
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC 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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

OD Guidelines
Denial Letters 1/28/09 and 2/10/09
Peer Reviews 1/27/09 and 2/9/09
Records from Dr. 1/7/09 and 2/6/09
MRI 2/29/08

PATIENT CLINICAL HISTORY SUMMARY

This is a xx year old man with left shoulder pain after an injury 3 years ago. He apparently repair of the supraspinatus muscle and subacromial decompression, AC joint debridement and a SLAP repair in 2006. He then had two additional arthroscopic repairs in 2007, but had ongoing persistent pain and postoperative therapy. An MRI in 2008 showed rotator cuff tear and impingement, subacromial bursitis, AC arthropathy. Dr. noted Dr. in contemplate additional surgery. Dr. examination showed the prior surgical scar, deltoid atrophy and restricted shoulder motion. A request for suprascapular nerve blocks was denied.

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

Physical therapy has its role. There are recommendations for a trail of PT before any surgery is undertaken for a rotator cuff repair. Obviously, he is way along from such acute care. The role for therapy alone for a frozen shoulder is also limited. Physical Therapy is justified in a decreased frequency. Additional surgery is contemplated. The intense therapies justified in the ODG should be given in the postoperative management of the patient. While range of motion would be encouraged, this does not require the intensity of the therapies requested. A home and self directed program would be more appropriate as recommended by the OD Guidelines.

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 ERVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)