

Notice of Independent Review Decision

**DATE OF REVIEW:** 06/30/2009

**IRO CASE #:**

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

PT 2x wk x 4 wks

**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 PT 2x wk x 4 wks is medically necessary to treat this patient's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Information for requesting a review by an IRO – 06/22/09
- Preauthorization Determination letter – 05/19/09, 06/02/09

- Appeal letter from Dr. – 06/15/09
- Office notes by Dr. – 02/20/09, 05/18/09
- Operative report for rotator cuff repair – 01/15/09
- Physical therapy initial evaluation – 03/02/09
- Daily physical therapy notes – 03/04/09 to 05/14/09
- Prescription from Dr. for home exercise program – 04/13/09

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury to her right shoulder on xx/xx/xx. She underwent rotator cuff repair to the right shoulder in xx/xx/xx. A revision of this repair was performed on 01/15/09. Post-operatively, she received 18 sessions of physical therapy. Additional physical therapy sessions have been requested.

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

This patient underwent a primary rotator cuff repair to the right shoulder in x/xx/xx. Subsequently she suffered a recurrent rotator cuff tear and underwent revision of rotator cuff repair on 01/15/09. Post operatively, she received 18 sessions of physical therapy. She made significant improvement in her range of motion. Addition benefit is to be achieved by additional physical therapy sessions. The ODG, 2009 Shoulder chapter, physical therapy passage is silent on the number of sessions over a particular period of time for revision rotator cuff repair. The provider has provided a justification for continue supervised physical therapy in a letter dated 06/15/09. Therefore, the additional physical therapy is determined to be medically necessary.

**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)**