

SENT VIA EMAIL OR FAX ON  
Jun/17/2009

## **IRO Express Inc.**

An Independent Review Organization

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**DATE OF REVIEW:**

Jun/17/2009

**IRO CASE #:**

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

Physical Therapy 3 X 4 (active and passive modalities) Left Shoulder

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

Doctor of Medicine (M.D.)

Board Certified in 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 5/1/09 and 5/18/09

Dr. 2/12/09 thru 3/18/09

MRI 3/19/09

Ortho Group 4/21/09

**PATIENT CLINICAL HISTORY SUMMARY**

The patient injured her shoulder at work xxxx months ago. She has had work restrictions, oral steroids, and a subacromial steroid injection. She apparently has had 6 PT visits (no PT records provided). 12 more visits have been denied by the insurance company as medically unnecessary. MRI shows a partial rotator cuff tear.

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

ODG guidelines allow for 10 PT visits for this diagnosis. The patient is starting with a new provider, so these 10 visits would be appropriate. However, the IRO request is for 12 visits. There is nothing in the medical records that would suggest that this patient would need PT in excess of the ODG guidelines. The request is not medically reasonable or necessary.

**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)