

SOUTHWEST MEDICAL EXAMINATION SERVICES, INC.  
12001 NORTH CENTRAL EXPRESSWAY  
SUITE 800  
DALLAS, TEXAS 75243  
(214) 750-6110  
FAX (214) 750-5825

---

Notice of Independent Review Decision

**DATE OF REVIEW:** August 22, 2010

**IRO CASE #:**

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

Physical therapy/Occupational therapy three times a week for four weeks for left and right shoulder.

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

AMERICAN BOARD OF ORTHOPEDIC SURGEONS

**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**

Medical records from the URA include:

- Official Disability Guidelines, 2008
- Texas Department of Insurance, 08/02/10
- MRI, 08/19/08, 03/06/09
- Review Med, 09/10/08
- Orthopaedics and Sports Medicine, 06/03/09, 07/02/09
- M.D., 07/16/09
- Doctors Hospital, 07/16/09
- M.D., 07/27/09, 09/02/09, 10/08/09, 10/20/09, 11/12/09, 06/03/10
- Surgery Center, 10/02/09
- Imaging, 10/20/09
- Physical Therapy, 06/03/10, 06/16/10, 06/18/10
- Preauthorization Request, 06/18/10, 07/12/10
- M.D., 06/22/10
- Mr., 07/10/10
- M.D., 07/15/10

Medical records from the Requestor/Provider include:

- M.D., 07/10/08, 08/25/08, 09/30/08, 11/13/08, 02/17/09, 03/12/09, 03/26/09, 03/26/09, 04/16/09, 05/12/09, 07/02/09, 07/27/09, 09/02/09, 10/08/09, 10/20/09, 11/12/09

**PATIENT CLINICAL HISTORY:**

This is a gentleman whose date of birth is xx/xx/xx. His injury was in xxxx. Reportedly, the patient injured his cervical spine and both shoulders. The patient has had several surgical procedures on his neck. At the time of the injury, the patient had a fracture of the shoulder with a tear of the rotator cuff.

On March 6, 2009, the patient underwent a repeat MRI of the left shoulder that revealed postoperative changes and a recurrent full-thickness tear of the supraspinatus. The patient also was felt to have a SLAP tear. An MR arthrogram confirmed the rotator cuff tear, and the patient underwent a revision repair in October of 2009.

The patient also has rotator cuff pathology on the right shoulder. The patient was noted to be 11 months after a right shoulder SLAP repair on November 12, 2009.

The patient's initial visit in physical therapy appears to be June 16, 2010. The patient was not working, although his job was xxxx. The patient has had six shoulder surgeries since the summer of 2006, and two prior cervical surgeries. The patient had physical therapy for the first two surgeries and found a little help with treatment. The patient has not had physical therapy for his last two shoulder surgeries. The plan of care is delineated on June 16, 2010.

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

Based upon the medical records, I am asked if I uphold or overturn the denial of further physical therapy.

Based upon the Occupational Disability Guidelines and the lack of specific information in the medical records as to range of motion, it is not likely that the patient is going to improve significantly with physical therapy. The patient underwent surgical procedures in 2009. It is unlikely that the patient will gain significant range of motion over a year later, by initiating physical therapy at this time. The operative surgeon's responsibility would have been to start the physical therapy much closer to the time of surgery where it may have made some good. At this time, the scientific evidence is unclear that the patient would improve. Therefore, based upon my experience as a board certified orthopedic surgeon and the Occupational Disability Guidelines, I uphold the previous adverse determination.

Please let me know if any further information is necessary in this regard.

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)