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Notice of Independent Review Decision

DATE OF REVIEW: 1/18/10

IRO CASE #:

Description of the Service or Services In Dispute
Physical therapy left shoulder 12 visits

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

Physician Board certified in Physical medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld	(Agree)
X Overturned	(Disagree)
Partially Overturned	(Agree in part/Disagree in part)

Description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse determination letters, 12/28/09, 12/18/09, 12/2/09
Letter approval 9/30/09
Letter 12/21/09 Sports Therapy
MRI shoulder report 10/28/09
Physical therapy notes 12/09, 10/09, 9/09
Office notes, Dr. 12/09, 11/09
Review, Dr., 11/9/09
Records, 9/09 – 12/09
ODG guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is male who in xx/xx/xx felt a pop in the left shoulder . There was immediate, constant and diffuse pain throughout the shoulder. Initial x-rays were negative. The patient was treated with work restrictions, pain medications and four sessions of physical therapy for sprain/strain of the left shoulder. The patient did not improve much from the four visits. A 10/28/09 MRI documented partial thickness tearing at the distal attachment of the subscapularis tendon, no full thickness rotator cuff tear, moderately severe osteoarthritis in the acromioclavicular joint, and a Type I or II acromion. Orthopedic evaluation led to physical therapy for the partial thickness rotator cuff tear, and the patient completed six visits, working mostly on range of motion, stretching, modalities and manipulation. The patient continued to have significant weakness in the shoulder. A little improvement has been documented.

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

I disagree with the decision to deny the requested physical therapy. The patient has a partial tear of his rotator cuff tendon. After six visits of physical therapy he has improved, and continues to have severe strength deficits in the shoulder. Continued physical therapy is medically necessary and reasonable to maximize his range of motion and increase his strength. He will be instructed in a home exercise program that he can continue on his own after completion of the physical therapy.

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)**