

SENT VIA EMAIL OR FAX ON
Nov/22/2010

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Nov/22/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
PT 3 X 4 Right Shoulder

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 9/24/10 and 10/19/10
Select PT 12/3/08 thru 9/21/10
Dr. 8/30/10 thru 10/4/10
Peer Review 10/18/07
Dr. 11/1/07 thru 10/5/10
MRI 11/6/07
Lab Report 12/9/08
Dr. 10/12/10
URA 438 pages 11/28/06 thru 11/11/10
Dr. 6/16/10
Shoulder Exam 6/22/10

6/22/10 thru 8/5/10

PATIENT CLINICAL HISTORY SUMMARY

This is a man who sustained several problems with an injury in xx/xx when he was reportedly in a rear end accident. He sustained multiple injuries that included cervical and disc problems a right shoulder labral tear and a left hip labral tear. He had a repair of the right shoulder in 10/08, but had a wound infection and a pneumothorax post surgery. He has had a cervical rhizotomy.

He had a fall in xxxx of this year and was seen in an emergency room for shoulder pain. The x-ray showed no fracture. He was diagnosed with a contusion.

Dr. noted (8/10/10) of his chronic right shoulder pain with radiation and subsequent cervical radiculopathy (8/26/10). Dr. saw him on 8/10/10 and felt he had right rotator cuff impingement, AC arthrosis and bicipital tendinosis. He noted improvement after the prior labral repair 2 years earlier. He advised PT and appealed a denial in the 9/27/10 letter.

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

There is a role for therapy for the impingement syndrome and tendinosis. The ODG approves 24 visits post arthroscopic shoulder repair over 14 week. His surgery was 2 years ago. The problem he is symptomatic in the shoulder. The diagnosis of impingement appears to be a new one as Dr. noted the symptoms have developed since March. If it were from the original injury, the therapy would be approved only for 14 weeks after the surgery 2 years ago. This would also not justify the treatment. Therefore, based on the medical records, the request does not conform to the ODG.

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 REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A

DESCRIPTION)

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