

SENT VIA EMAIL OR FAX ON  
Aug/30/2010

**True Decisions Inc.**  
An Independent Review Organization  
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**NOTICE OF INDEPENDENT REVIEW DECISION**

**DATE OF REVIEW:**  
Aug/30/2010

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**  
Op Physical Therapy 3 X wk X 6 wks for the Right Shoulder

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

**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  
Dr. –Operative Report: 05/14/10  
Dr. Office Records: 05/18/10; 07/24/10  
Physical Therapy Records: 05/25/10, 07/19/10  
Peer Reviews: 07/26/10, 08/02/10

**PATIENT CLINICAL HISTORY SUMMARY**

This is a right hand dominant male claimant with a reported right shoulder injury that occurred while at work on xx/xx/xx when he slipped getting of some equipment, grapped on the keep from falling and pulled his shoulder feeling a pop. The claimant underwent a right shoulder arthroscopy, exam under anesthesia, subacromial decompression, distal clavicectomy and debridement of his partial articular-sided tendon avulsion (PASTA) lesion along with a labral debridement on 05/14/10. The initial 05/25/10 physical therapy evaluation revealed decreased passive range of motion and strength with functional deficits and increased pain. The 07/19/10 physical therapy record revealed the claimant completed 17 sessions with continued pain, decreased active and passive range of motion and limited functional activities. On 07/24/10, Dr. noted the claimant had clinically improving range of motion with continued restrictions and muscle weakness. Dr. requested authorization for 18 additional physical therapy sessions three times a week for 6 weeks.

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

The ODG guidelines allow up to twenty-four visits over fourteen weeks. The claimant still had restricted range of motion and strength. Based on the records provided the claimant has undergone seventeen sessions of physical therapy and the IRO reviewer would agree that six additional therapy visits two times a week for three weeks, to be consistent with OD Guidelines and evidence based medicine, would be necessary. However, since an IRO reviewer cannot recommend or change a request, the 18 sessions that are requested exceed the guidelines and therefore are not medically necessary.

**ODG Physical Therapy Guidelines:** Allow for fading of treatment frequency plus active self-directed home PT.

- **Rotator cuff syndrome/Impingement syndrome:** Post-surgical treatment, arthroscopic: 24 visits over 14 weeks

**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)