



---

Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:  
877-738-4395

## **Notice of Independent Review Decision**

### **IRO REVIEWER REPORT – WC (Non-Network)**

---

**DATE OF REVIEW:** 02/23/12

**IRO CASE #:**

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

Physical therapy two to three times a week for four weeks

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

Board Certified in Orthopedic 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)

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

Physical therapy two to three times a week for four weeks - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Evaluations from dated 10/21/11 and 11/08/11

An evaluation from dated 12/06/11

Therapy referral from the dated 12/06/11

Physical therapy reevaluated from dated 12/09/11

Fax cover sheet from dated 12/12/11

Authorization Determination Notices from dated 01/10/12 and 02/03/12

Undated carrier notes for the claim

The Official Disability Guidelines (ODG) criteria used was not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

On xx/xx/xx, evaluated the patient for his shoulder pain. The MRI was reviewed. Range of motion was 50% of normal. Sensation and motor examinations were normal. The diagnosis was a sprain of the rotator cuff. performed a left shoulder injection on 11/08/11. Physical therapy was recommended. examined the patient on 12/06/11 and he reviewed the MRI, which was noted to be normal. The patient wanted to continue in physical therapy, which felt was appropriate. It was noted he was tender in the region of the biceps tendon of the left shoulder and noted an injection may be appropriate if that did not improve. He recommended therapy two to three times a week for four weeks. reevaluated the patient in therapy on 12/09/11. He had continued left shoulder pain, but it was on an intermittent basis. He was compliant with a home exercise program. Continued therapy two to three times a week for four weeks was recommended. On 01/10/12, on behalf of provided a non-authorization for the requested therapy. On 02/03/12, also on behalf of provided another non-authorization notice for the requested physical therapy.

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

I do not feel that there is enough documentation to support continued physical therapy. The patient has the diagnosis of a sprain to the rotator cuff and the MRI was noted be normal. The patient received a course of physical therapy, but the amount of sessions was not clear based on the documentation provided. In the 12/09/11 physical therapy reevaluation, his left shoulder flexion was 120 degrees, abduction was 50 degrees, internal rotation was 28 degrees, and external rotation was 25 degrees. The patient's pain level and range of motion had improved and he was compliant with a home exercise program. The patient, at this time, should be well versed in a home exercise program and does not require additional skilled therapy. Therefore, the requested physical therapy two to three times a week for four weeks is not reasonable or necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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)

Medical Disability Adviser