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IRO Certificate #4599

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/16/12

**IRO CASE NO.**

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

Physical Therapy: Therapeutic Exercise/97110; Neuromuscular Re-Ed./97112; Manual Therapy Techniques/97140; E-Stimulation/GO283

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

Physician Board Certified: **Physical Medicine & Pain Management**

***DESCRIPTION OF THE REVIEW OUTCOME THAT CLEARLY STATES WHETHER OR NOT MEDICAL NECESSITY EXISTS FOR EACH OF THE HEALTH CARE SERVICES IN DISPUTE.***

**REVIEW OUTCOME**

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

Upheld	(Agree)	<input checked="" type="checkbox"/>
Overtured	(Disagree)	<input type="checkbox"/>
Partially Overtured	(Agree in part/Disagree in part)	<input type="checkbox"/>

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

**PATIENT CLINICAL HISTORY SUMMARY**

Patient is a female who reportedly had an injury to her right shoulder. It wasn't clear how the injury occurred. She later underwent a surgical procedure on xxxx for rotator cuff repair, subra-chromial decompression and a Mumford Procedure. Post-operatively, she had physical therapy and home exercise instructions. The patient was prescribed ibuprofen and another pain medication provided PRN (as needed). She returned to work but with lifting restrictions. She later had a subra-chromial cortiscosteroid injection. A report of 4/20/12 indicated she was continuing her work duties with the same restrictions. She continued with further physical therapy. There was an initial P/T evaluation report on 8/20/12 and then a final P/T report on 10/15/12. Patient had completed her physical therapy a few days before the final report and had achieved very minimal/poor progress.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND**

**CONCLUSIONS USED TO SUPPORT THE DECISION**

I agree with the benefit company's decision to deny the requested services. Reason/rationale for decision: The 8 additional therapy treatments are not justified for the injury. Patient had already received 33 treatments. The ODG recommend a maximum of 24 physical therapy sessions, post-operatively. Patient should know her self/home directed rehab exercises at this point. The 8 additional treatments would exceed the guidelines, and there were no exceptional factors evident. The MRI of 7/13/12 reveals no evidence of new tears in the right shoulder. Also, on 10/30/12, according to the paperwork, the IMO reviewer had spoken with the physician assistant and "agreed no further formal therapy was needed".

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL  
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & 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  
DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES  
(PROVIDE DESCRIPTION)