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IRO Certificate #4599

**Notice of Independent Review Decision**

**DATE OF REVIEW:** January 23, 2013

**IRO CASE NO.**

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

Physical Therapy/12 sessions, RT Shoulder Pain, CPT: 97002, 97110, 97010, 97530, 97140

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

Physician Board Certified: **Physical Medicine & Rehabilitation**

**REVIEW OUTCOME**

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

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

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Adverse Determination Letter: 11/02/12  
Response to Request for Reconsideration, 11/30/12  
Appeal/Reconsideration, New Doctor RX & Notes; 11/20/12  
Clinic Notes, (2) 12/27/12, 12/03/12  
MRI/Rt Shoulder w/wo contrast) 5/31/12  
Operative Report, *Procedure*: Diagnostic Arthroscopy Rt Shoulder; 7/11/12  
Follow-up Clinic Notes, 11/08/12  
ODG

**PATIENT CLINICAL HISTORY SUMMARY**

The client is a female with history of a lifting injury involving the right shoulder, occurring in xx/xxxx. An MRI revealed evidence of tendon and labrum tears. Patient underwent diagnostic arthroscopic surgery on 7-1-12. Later postoperative rehabilitation included 40 visits of physical therapy. She obtained relatively good range of motion recovery/improvement, but some residual focal pain/weakness/weakness complaints remain. An October, 2012 request for 12 more physical therapy sessions was submitted. This was initially denied, and the second reviewer concurred with the denial.

**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 opinion:*** Patient has shown sufficient improvement from the clinical physical therapy. A home/self exercise program at this time should be continued/encouraged without the need for further clinic therapy treatment/instruction.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (cont'd)**

The ODG treatment of shoulder guidelines (updated November, 2012) for post-surgical rotator cuff repair: recommendation of up to 24 treatments over a 14 week period. This patient had received 40 visits/treatments at the time of this recent request for 12 more sessions. The request does not appear adequately justified.

**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 X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

**ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X**

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)