

# P-IRO Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE NOTICE SENT TO ALL PARTIES:

Jul/08/2013

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

12 PT visits for the right shoulder

### A 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)

**Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.**

### INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines  
Clinical notes 02/28/13-05/21/13  
Operative note 02/20/13  
Therapy notes 02/15/13-06/04/13  
Previous utilization reviews 06/03/13 and 06/10/13

### PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female who reported an injury to her right shoulder. Operative report dated 02/20/13 detailed the patient stating that the initial injury occurred when she had a fall resulting in a proximal humerus fracture. The patient underwent open reduction internal fixation at the right proximal humerus. Clinical note dated 02/20/13 detailed the patient reporting a small amount of tingling in the fingers. However this improved with time. Clinical note dated 03/20/13 detailed the patient demonstrating 50 degrees of right shoulder elevation. The patient was recommended to initiate therapy at that time. Clinical note dated 04/09/13 detailed the patient passive elevating the right shoulder to 80 degrees. The patient also had 4/5 strength. Therapy note dated 06/04/13 detailed the patient completing 27 physical therapy sessions as part of the post-operative care following right shoulder ORIF.

Utilization review dated 06/03/13 for the request for 12 physical therapy sessions for the right shoulder resulted in denial secondary to lack of information for any compelling factors that would warrant the need for additional physical therapy beyond the recommended 24 visits.

Utilization review dated 06/10/13 for additional 12 physical therapy sessions for the right shoulder resulted in denial secondary to lack of information for any exceptional factors that would warrant the need for additional physical therapy.

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

Clinical documentation submitted for review notes the patient previously undergoing ORIF following a humeral fracture. Official Disability Guidelines recommend 24 physical therapy sessions as part of post-operative care following a procedure of this nature. Clinical documentation detailed the patient previously completing 27 post-operative physical therapy sessions to date. The additional request for 12 additional physical therapy sessions exceeds guideline recommendations. No information was submitted for any exceptional factors the patient presented with to warrant additional physical therapy following a full course of treatment. Given this the request does not meet guideline recommendations. As such, the clinical documentation provided for review does not support this request at this time.

**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)