



14785 Preston Road, Suite 550 | Dallas, Texas 75254  
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**Notice of Independent Review Decision**

**DATE OF REVIEW: 9/15/2013**

**IRO CASE #**

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

12 PHYSICAL THERAPY 3X4 W, RIGHT SHOULDER

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

M.D. Board Certified in Physical Medicine and Rehabilitation.

**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**

Document Type	Date(s) - Month/Day/Year
Department of Insurance Notice of Case Assignment	8/26/2013
Utilization Review Determinations	7/19/2013-8/06/2013
IRO Report	8/05/2013
Pre-Authorization Request	6/24/2013
Office Visit Note	6/27/2013-7/17/2013
Letter of medical Necessity	7/30/2013
Radiology Reports	8/15/2012-6/13/2013
Clinical Notes	9/26/2012-8/26/2013

**PATIENT CLINICAL HISTORY [SUMMARY]:**

Patient is a female who slipped on a mat and bruised her shoulder and chest on xx/xx/xx. She has complained of shoulder pain. She had 10 visits of physical therapy. She was seen and found to have excellent painless range of motion of the shoulder; return to work was recommended. Additional PT has been requested. She has had 2 orthopedic peer reviews and one physical medicine and rehabilitation peer review. The notes provided indicate this claimant may have had a sprain to the shoulder or impingement. She did improve with therapy and the



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notes indicate she had complete painless range of motion of the shoulder. Her treating physician indicates she can return to work.

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

Per ODG references, the requested "12 physical therapy 3x4 w, right shoulder" is not medically necessary. The patient completed the ODG recommended 10 sessions of physical therapy for her injury. There are no exceptional factors of delayed recovery documented. This claimant should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.

**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 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