



PROFESSIONAL ASSOCIATES

DATE OF REVIEW: 05/04/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work hardening five times a week for six 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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

MRIs of the bilateral shoulders interpreted by, M.D. dated 09/19/06
An evaluation with, M.D. dated 09/29/06

Physical therapy orders from, M.D. dated 10/06/06, 11/01/06, 12/13/06, and 01/22/07

Physical therapy evaluations with, P.T. dated 10/10/06 and 11/06/06

A letter of adverse determination from, Utilization Review Nurse, dated 10/16/06

A request from Dr. dated 10/27/06

Evaluations with Dr. dated 11/01/06 and 03/12/07

A letter of adverse determination from, L.P.N at dated 11/03/06

A discharge note from Ms. dated 01/23/07

A Functional Capacity Evaluation (FCE) with, P.T. dated 03/01/07

A prescreening evaluation from, Ph.D. dated 03/01/07

A letter of non-certification from, M.D. at dated 03/22/07

A Concentra Utilization Review from Ms. dated 03/27/07

A letter of non-certification from, M.D. at dated 04/03/07

PATIENT CLINICAL HISTORY [SUMMARY]:

MRIs of the shoulders interpreted by Dr. on revealed a possible tear or tendinopathy with degenerative changes in the left shoulder and a rotator cuff tear and impingement syndrome in the right shoulder. On, Dr. recommended further physical therapy. On 10/16/06, Ms. wrote a letter of non-authorization for occupational therapy. On 11/01/06, Dr. requested physical therapy. On 11/03/06, Ms. wrote a letter of adverse determination for CPM for the right shoulder. On 12/13/06 and 01/22/07, Dr. recommended further physical therapy. On 01/23/07, Ms. discharged the patient from physical therapy. Based on an FCE with Ms. on 03/01/07, a work hardening program was requested as the patient functioned in a medium physical demand level. On 03/01/07, Dr. also requested the work hardening program. On 03/22/07, Dr. wrote a letter of non-certification for work hardening. On 04/03/07, Dr. also wrote a letter of non-certification for the work hardening program.

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

The work hardening program five times a week for six weeks is certainly overkill. That would be 30 visits over six weeks and in my opinion, this would be over treatment. This patient has had therapy for quite sometime. The patient appears to needs a short work hardening program as he is noted to be at a medium function level along with having some psychological issues. The claimant would probably benefit from no more than three times a week for three weeks of work hardening, this would probably be the upper limits of what would find to be reasonable and necessary, considering the amount of therapy the patient has already had. ACOEM and ODG are very specific about work hardening and work conditioning guidelines, and this amount of work hardening is not justified.

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)**