MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: December 7, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The requested service, 10 sessions of a work hardening program (80 hours), is not medically necessary for treatment of the patient's medical condition.

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:

[X] Upheld **(Agree)**

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

The requested service, 10 sessions of a work hardening program (80 hours), is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated October 2010.
2. TDI Notice to IRO of Case Assignment dated 11/15/10.
3. Letter from DC dated 11/11/10.
4. Medical record from MD dated 5/4/10, 2/12/10, 2/2/10, 1/8/10, 1/5/10, and 11/16/09.
5. Forecasted Compliance Sheet.
6. Progress note from Medical Healthcare dated 11/17/10, 10/18/10, 9/15/10, 8/9/10, 7/6/10, 5/10/10, 4/5/10, and 3/4/10.
7. Mental Health Evaluation by PhD dated 9/21/10.
8. Outcomes Grid dated 9/21/10.
9. Vocational Assessment Note dated 9/21/10.
10. Note from PTT undated.
11. Functional Capacity Evaluations dated 9/14/10 and 9/15/09.
12. Work Hardening Two Week Summary.
13. Operative Report dated 12/7/09.
14. Evaluation from Interventional Pain Specialists dated 7/1/10.
15. Consultation performed by MD dated 5/13/10.
16. Report from Coast Medical Evaluation dated 7/14/10.
17. MRI of shoulder dated 6/8/10.
18. Arthrogram of shoulder dated 6/8/10.
19. MRI of shoulder with 3D dated 5/26/10.
20. Workers' Compensation New Patient Evaluation dated 12/18/09.
21. Texas Workers' Compensation Work Status Reports.

PATIENT CLINICAL HISTORY [SUMMARY]:

A male patient has requested authorization for 10 sessions of a work hardening program (80 hours). The Carrier has denied this request indicating that the requested services are not medically necessary. A review of the record indicates the patient sustained an injury on xx/xx/xx. He was found to have a full thickness supraspinatus rotator cuff tear involving his right shoulder as well a superior labrum tear. He is now status post surgery, injections, physical therapy and prescription medications. The patient's provider indicates the patient has had marginal results with these modalities. The provider reports that the patient has completed 10 sessions of an interdisciplinary work hardening program with favorable results. The provider has recommended 10 additional sessions of a work hardening program. The Carrier indicates the requested service is not medically necessary. According to the review performed by the Carrier, evidence based guidelines support a maximum of 10 sessions of work hardening program services.

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

The requested 10 sessions of a work hardening program (80 hours) are not medically necessary. According to the Official Disability Guidelines (ODG), there is questionable medical necessity for a patient to participate in work hardening if the patient is returning to a job with physical demand levels of sedentary or sedentary light. Review of the evidence submitted demonstrates a lack of significant progress to date. This patient's current level of physical capacity based on the submitted functional capacity evaluation appears to be at the lower levels of work capacity. As such, the medical necessity for additional work hardening sessions is not established.

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 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[**X]** 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)