IMedReviews
7331 Carta Valley Drive | Dallas, Texas 75248 | Phone: 214 732 9359

Notice of Independent Review Decision

DATE OF REVIEW: 4/11/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Work Conditioning 5x2 4hrs per day right shoulder

975454 97546

Non-Certified Quantity: 10

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

M.D. whose specialty is Occupational Medicine

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
Notice of Case Assignment	3/23/2011
Health Care	3/23/2011
Notification of UR Determination	3/16/2011

Physical Therapy Functional Capacity Evaluation Request to continue work conditioning Outpatient Therapy Prescription Re-Evaluation Appeal Reconsideration	 1/05/2011 2/25/2011 2/23/2011 1/27/2011 3/09/2011
Imaging of Lubbock MRI Rt Shoulder W/O Contrast Report	 9/09/2010
M.D. Clinical Notes	 10/06/2010-3/23/2011

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on x/xx/xx affecting his right shoulder. He attended physical therapy for 6 sessions and due to lack of improvement an MRI was ordered. A right shoulder MRI on 9/9/10 showed complete rotator cuff tear and AC joint arthropathy. He had surgery for repair of the rotator cuff on 10/21/10. He attended physical therapy rehabilitation - 36 sessions and a work conditioning program for 2 weeks. A functional capacity evaluation (FCE) on 1/5/11 showed that the patient has normal ROM and needs to improve rotator cuff strength to meet a heavy physical demand level.

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

The request for additional work conditioning does not meet ODG guidelines.

ODG guidelines stipulate the following:

(14) *Trial:* Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.

(21) *Repetition:* Upon completion of a rehabilitation program (e.g., work conditioning, work hardening,

outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

The patient has completed 36 sessions of physical therapy and 2 weeks of a work conditioning program for the right rotator cuff repair. Therefore repetition is not warranted.

ODG GUIDELINES REGARDING APPROVAL FOR ADMITTANCE TO A WORK CONDITIONING AND HARDENING 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 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**