

## Notice of Independent Review Decision

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### Notice of Independent Medical Review Decision

#### Reviewer's Report

**DATE OF REVIEW:** April 29, 2011

**IRO CASE #:**

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

Work Conditioning x 10 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)

The requested service, work conditioning x 10 right shoulder, is medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 4/6/11.
2. Form for Requesting a Review by an Independent Review Organization (IRO).
3. Notice of Assignment of Independent Review Organization dated 4/11/11.
4. Medical records from Spine and Rehab dated 3/7/11, 2/14/11, 2/8/11, 1/27/11, 12/21/10, 11/16/10, 11/10/10, and 8/24/10.

5. MRI right shoulder dated 11/17/10 and 11/25/09.
6. Medical records from Medical Centers dated 1/15/10, 12/3/09, and 8/21/09.
7. Medical record from MedGroup dated 2/9/10.
8. MRI right knee dated 5/9/02.
9. Letter of Reconsideration from D.C. dated 2/14/11.
10. Request for IRO for Work Conditioning dated 3/31/11.
11. Letter from patient dated 1/28/11.
12. Designated Doctor report dated 10/20/03.
13. Medical records signed by the patient dated 2/14/11, 1/12/11, 12/1/10, and 11/10/10.
14. Denial Documentation.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

A review of the record indicates that a male sustained a work injury on xx/xx/xx resulting in right shoulder pain. He participated in conservative treatment with medications, passive therapies and work restrictions. The patient underwent surgery in January 2010 which was followed by passive therapy in July 2010. On 2/14/11, the patient's physician noted right shoulder ranges of motion included the following: flexion – 90/150; extension – 30/40; internal rotation – 65/80; external rotation – 45/90; abduction – 90/150; and adduction – 25/30. A physical performance test showed that the patient was not able to perform at the level of physical demand his employer required. The physician noted that the patient was evaluated by a designated doctor who determined that he would be able to return to work on a restricted basis however the restrictions placed on the patient do not comply with his job title. The patient's treating physician has requested authorization for 10 sessions of a work conditioning program.

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

Review of the submitted documentation as well as Official Disability Guidelines supports the requested work conditioning as medically necessary for this patient. The patient had an injury to his shoulder for which he underwent surgery. He is now 15 months status post surgery and has not been able to return to his former level of function. According to the results of a physical performance exam, the patient is not able to meet the physical demands of his former job. The results of this test are adequate to establish the patient's functional ability. Although a request for physical therapy was denied, the patient has been participating in passive therapy and there is a documentation of a home exercise program. Furthermore, there is no evidence of any psychosocial, attitudinal or drug barriers that would be a contraindication to participation in work conditioning. The patient is now at the stage that he can work on strengthening his muscles to improve his function and a work conditioning program would be medically appropriate and necessary at this time.

**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 (PROVIDE A DESCRIPTION)