SENT VIA EMAIL OR FAX ON
Oct/21/2011

Pure Resolutions Inc.

An Independent Review Organization
990 Hwy 287 N. Ste. 106 PMB 133
Mansfield, TX 76063
Phone: (817) 405-0870
Fax: (512) 597-0650
Email: manager@pureresolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Oct/20/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work Condtioning 5 X wk X 2 wks left shoulder

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

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male whose date of injury is xx/xx/xx. The mechanism of injury is not described, but the claimant is noted to have sustained an injury to the left shoulder. He is status post left shoulder rotator cuff repair performed 03/18/11. Records indicate the claimant also participated in 33 sessions of physical therapy. A functional capacity evaluation was performed on 07/21/11 at which time it was noted the claimant was currently functioning at heavy physical demand level. At the time of injury he was functioning at medium heavy physical demand level. The evaluator on functional capacity evaluation noted that based on this examination it was felt that the claimant could return to work without restrictions.

A preauthorization request for work conditioning 5 times a week x 2 weeks for the left

shoulder was reviewed on 08/05/11 and recommended as non-certified. The reviewer noted the claimant is status post left shoulder rotator cuff repair. Per medical report dated 07/29/11 the claimant complains of left shoulder pain rated 5/10 with numbness in the left hand. Examination revealed moderate tenderness on palpation 0 to 1+ swelling and within normal ROM. It was noted that progress reports and previous physical therapy to objectively document the claimant's response was not included in the records provided. No functional capacity evaluation report was provided to indicate the claimant's current physical capabilities were significantly less than those required by his particular job. Return to work plan was not documented. There also was no documentation of unsuccessful attempts of the claimant to return to work. As such, the request was not substantiated at that time.

A reconsideration request for work conditioning was reviewed on 08/19/11 and the proposed treatment was recommended for non-certification as medically necessary. The reviewer noted that the documentation submitted for review elaborates the claimant complaining of left shoulder pain with associated numbness in the hand. Current evidence based guidelines recommend work conditioning program provided the claimant meets specific criteria. No documentation was submitted for review regarding the claimant's previous involvement with conservative treatment to include physical therapy. Additionally, the request for total 40 hours exceeds guideline recommendations. Given the lack of documentation regarding the claimant's previous involvement with physical therapy as well as excess of nature, the request does not meet guideline recommendations. As such, the documentation submitted for review does not support the request at this time.

An addendum to the review noted that additional documentation was received including functional capacity evaluation dated 07/21/11 and therapy notes dated 12/15/10-07/08/11. However, it was noted that the request was for total of 40 hours which exceeds guideline recommendations.

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

Based on the clinical information provided, the request for work conditioning 5 times a week x 2 weeks to the left shoulder is not indicated as medically necessary. The claimant sustained an injury to the left shoulder on xx/xx/xx and underwent left shoulder rotator cuff repair, acromioplasty and distal clavicle resection on 03/18/11. He participated in extensive course of pre and postoperative physical therapy. Functional capacity evaluation performed on 07/21/11 noted that the claimant currently is functioning at heavy physical demand level, and at the time of injury was functioning at medium heavy physical demand level. The functional capacity evaluation reflects the claimant exceeds requirements for his job. The functional capacity evaluation examiner noted that based on evaluation was felt the claimant could return to work without restriction. As such, there is no medical necessity for work conditioning program, as the claimant exceeds physical demand requirements for his job. Moreover, the request as submitted for review was excessive based on ODG criteria.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

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

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES