

Core 400 LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Sep/06/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional work hardening five times a week for two weeks to the right shoulder 97545

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

MD, Board Certified in Anesthesiology and Pain Management

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

Official Disability Guidelines-Treatment for Workers' Compensation, Chapter: Shoulder

Adverse determinations dated 08/15/11, 07/13/11

Letter dated 08/23/11

Work hardening program preauthorization request dated 07/08/11

Reconsideration dated 07/27/11

Patient face sheet, undated

Job description, undated

Office visit note dated 06/15/11, 02/14/11, 12/02/10

Work hardening plan and goals of treatment dated 06/15/11

Functional capacity evaluation dated 06/15/11

Initial behavioral medicine consultation dated 06/15/11

MRI of the right shoulder dated 11/17/10

Operative note dated 03/04/11

Letter of medical necessity dated 05/13/11

Handwritten progress notes dated 04/04/11, 03/14/11, 01/17/11, 12/16/10

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xxxx. He injured his shoulder. He underwent right shoulder arthroscopic subacromial decompression and bursectomy, repair of superior labrum anterior and posterior lesion and mini open rotator cuff repair on 03/04/2011. Initial behavioral medicine consultation dated 06/15/11 indicates that the patient has received "2 episodes of physical therapy and injections". Medication is listed as Ambien. BAI is 3 and BDI is 10. Diagnosis is pain disorder associated with both psychological factors and a general medical condition, chronic. Functional capacity evaluation dated 06/15/11 indicates that required PDL is heavy and current PDL is medium. A request for work hardening was denied on 07/13/11. It was noted that the patient has completed 10 prior sessions of work hardening, but there were no integrative summary reports or reassessment submitted which document the patient's compliance and significant gains. A reconsideration letter dated 07/27/11 explained that this patient has not undergone previous work hardening, and this is

the initial request. The patient has completed 10 sessions of physical therapy. The denial was upheld on appeal dated 08/15/11 noting that there is a need for clarification with regard to the request -- the clinical summary states the patient completed 10 work hardening sessions, but the report dated 07/27/11 states he has not had any work hardening before.

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

There is conflicting information regarding this patient's previous participation in work hardening. The patient underwent surgical intervention in March 2011; however, there is no comprehensive assessment of postoperative treatment completed to date to establish that the patient has undergone an adequate course of physical therapy with improvement followed by plateau. The patient does not present with significant psychological issues as evidenced by the patient's Beck scales. There is no specific, defined return to work goal agreed to by employer and employee submitted for review. Given the current clinical data, Additional work hardening five times a week for two weeks to the right shoulder 97545 is not found by this reviewer to be medically necessary.

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

ACOEM-AMERICA 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)