

US Decisions Inc.

An Independent Review Organization
9600 Great Hills Trail Ste 150 W
Austin, TX 78759
Phone: (512) 782-4560
Fax: (207) 470-1085
Email: manager@us-decisions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/05/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

additional work hardening, 5 times a week for two weeks, 8 hours/day

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

M.D., Board Certified Anesthesiology/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
Notification of reconsideration determination 02/09/12
Notification of adverse determination 12/27/11
Appeal request work hardening program additional 10 sessions 01/13/11
Preauthorization request 12/21/11
Work hardening weekly progress note week #2 12/15/11
Functional capacity evaluation 12/20/11 and 11/14/11
Psychological evaluation 11/16/11
Operative report right shoulder arthroscopy with subacromial decompression and acromioplasty, repair of SLAP lesion, joint synovectomy, removal of adhesions, open rotator cuff repair, and micro tenotomy 05/05/11
Office notes 08/10/11 and 06/29/11
Daily progress and therapy notes 08/15/11-11/30/11
MRI right shoulder 04/05/11
Weekly psychological status with instrument scores 11/16/11
Physical performance exam 08/11/11, 09/23/11

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was injured on xx/xx/xx while carrying a 10-foot ladder. The ladder started to fall and when the claimant tried to stop the ladder from falling he injured his right shoulder. On 05/05/11 the claimant underwent right shoulder arthroscopy with subacromial decompression, SLAP lesion repair, and open rotator cuff repair. He participated in 24 sessions of physical therapy, which helped somewhat. A work hardening program was recommended. He completed two weeks of work hardening with some improvement noted. An additional two weeks of work hardening has been requested.

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

The claimant is noted to have sustained an injury to the right shoulder on xx/xx/xx resulting in

surgical intervention on 05/05/11. Following surgery, he participated in post-op physical therapy. He participated in a work hardening program times two weeks. According to appeal request dated 01/13/12 it was noted that although he is able to lift at heavy level for floor lifting he continues to have difficulty with shoulder and overhead lifting over 26-41 pounds. He has not met a 100 pound lifting requirement with floor lifts and ability to carry, and has not met goals for tolerance to the full work-day. He has not met a plateau with treatment and can continue to work towards essential job duties in order to return to work safely. It was noted that symptoms of depression have increased with added activity; however, anxiety and fear of activity has continued to decrease during treatment.

Noting that the patient has made progress with the program to date, but continues with functional deficits, the reviewer finds there is a medical necessity for additional work hardening, 5 times a week for two weeks, 8 hours/day.

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)