IMED, INC.

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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
XX XX program – continuation XX hours

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
MD, Board Certified Orthopedic Surgery

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
X Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
XXXX. XXXX underwent XX therapy but continued to have pain. XXXX underwent XX XX XX on XXXX and XX XX XX on XXXX. XXXX participated in XX therapy after each surgery. XXXX has since attended XX hours of work conditioning and then XX sessions of XX XX program. XX XX progress report dated XXXX indicates that the patient was recommended for XX additional sessions. Office visit note dated XXXX indicates that the patient reports overall the symptoms are improved. XXXX has completed a XX XX program; however, XXXX feels XXXX could benefit from more particularly with regard to the XX XX which was the more recent surgery of the two. Current medication is XXXX.

Letter of reconsideration dated XXXX indicates that XX XX range of motion improved in flexion from XX to XX, adduction from XX to XX, internal rotation decreased from XX to XX and external rotation increased from XX to XX. Extension and abduction remained the same. XX XX range of motion increased from XX to XX in extension, XX to XX abduction, XX to XX adduction, XX to XX XX and XX to XX XX. Flexion remained XX degrees. Pain level decreased from XX/XX to XX-XX/XX. Maximum lift increased from XX to XX and maximum carry from XX to XX. PDL increased from medium to medium-heavy. The patient has a very XX physical demand job position to return to. XXXX had XX shoulder surgery and needs to be able to lift at times over XX pounds overhead. The patient continues to have a job available.

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

Based on the clinical information provided, the request for work XX XX – continuation XX hours is not recommended as medically necessary, and the previous denials are upheld. The patient has previously completed XX sessions of XX XX program. The Official Disability Guidelines state that "the entirety of this treatment should not exceed XX XX visits over XX weeks, or no more than XX hours (allowing for XX sessions if required by XX work, etc., over a longer number of weeks)." The submitted clinical records indicate that despite extensive XX XX therapy, a complete XX XX program and a complete XX XX program, the patient has failed to reach XXXX required physical demand level for return to work. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines.

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

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