

MedReview

DATE OF REVIEW: 04/27/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Twenty sessions of work hardening (97545, 97546)

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

Board Certified in Podiatry
Board Certified in Podiatric Surgery

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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with D.P.M. dated 02/07/06, 02/21/06, 03/14/06, and 03/27/06
Evaluations with M.P.T. dated 02/08/06, 02/21/06, and 03/08/06
An MRI of the left lower extremity interpreted by M.D. dated 02/16/06
A prescription from Dr. dated 03/08/06

Evaluations with M.D. dated 05/10/06, 06/13/06, 07/11/06, 08/17/06, 09/15/06, 11/08/06, and 11/16/06

An evaluation with an unknown provider (no name or signature was available) dated 06/13/06

A prescription from Dr. dated 06/13/06

An operative report from Dr. dated 08/07/06

A mental health evaluation with M.Ed., L.P.C. dated 10/13/06

Preauthorization requests from M.D. dated 10/19/06 and 10/20/06

A Functional Capacity Evaluation (FCE) with D.C. dated 02/01/07

A work hardening assessment with Ms. dated 02/02/07

A preauthorization request from Dr. dated 02/06/07

Letters of non-authorization dated 02/09/07 and 02/27/07

A request for reconsideration letter from Dr. dated 02/16/07

A letter written to from Dr. dated 04/11/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On 02/07/06, Dr. recommended x-rays of the left ankle, an MRI, and physical therapy. On 02/08/06, Mr. requested therapy three times a week for four weeks. An MRI of the left lower extremity interpreted by Dr. on 02/16/06 revealed a deltoid ligament injury. On 03/08/06, Mr. requested further physical therapy. On 05/10/06, Dr. recommended continued active rehabilitation. Left ankle surgery was performed by Dr. on 08/07/06. On 08/17/06, Dr. applied a short leg cast. On 10/13/06, Ms. requested a 20 session pain management program. On 11/16/06, Dr. felt the patient was at Maximum Medical Improvement (MMI). An FCE with Dr. on 02/01/07 revealed the patient functioned at a sedentary light physical demand level and a work hardening program was requested. On 02/06/07, Dr. requested 20 sessions of the work hardening program. On 02/09/07 and 02/27/07, wrote letters of non-authorization for work hardening. On 02/16/07, Dr. wrote a request for reconsideration letter. On 04/11/07, Dr. wrote a letter to requesting the work hardening program.

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

In my estimation, the 20 sessions of work hardening are reasonable and necessary. I feel this is reasonable and necessary due to the fact that according to the DWC Guidelines, work hardening is considered proper treatment and recommended for treating such injuries. This work hardening was also recommended by Dr., as well as Dr.. The whole basis of work hardening is to improve functional performance as well as strength, endurance, reduce pain, improve gait, and allow the patient to get back to her previous work position. I do feel that if she has these 20 sessions, she will be able to get back to work without restrictions. In conclusion, it is my opinion that the patient should have the 20

sessions of work hardening (97545, 97546) and it is reasonable and medically necessary as of the guidelines of the DWC.

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)