

# RYCO MedReview

## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/03/07

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Non-DWC exempt work conditioning

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

Licensed by the Texas State Board of Chiropractic Examiners

### **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.

Non-DWC exempt work conditioning - Overturned

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

A work hardening assessment psychological evaluation with M.Ed., L.P.C. dated 08/09/07

Preauthorization requests from, D.C. dated 09/06/07, 09/13/07, 10/02/07, and 10/19/07

A letter of non-certification, according to the ODG Guidelines, from, D.C. dated 09/18/07

Work conditioning with Dr. dated 09/20/07, 09/21/07, 09/24/07, 09/26/07, 09/28/07, 10/10/07, 10/11/07, 10/12/07, 10/15/07, 10/22/07, and 10/24/07

Evaluations with, D.P.M. dated 09/25/07 and 10/09/07

A Designated Doctor Evaluation from, D.O. dated 10/23/07

A letter of non-certification, according to the ODG Guidelines, from, D.C. dated 10/24/07

A request for reconsideration letter from Dr. dated 10/26/07

An evaluation with, D.C. dated 10/30/07

A letter of non-certification, according to the ODG Guidelines, from, D.C. dated 10/31/07 and 11/01/07

A letter to Ryco from, M.D. dated 11/16/07

No ODG Guidelines were provided from the carrier or the URA

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

On xx/xx/xx, Ms. felt the patient was a good candidate for a work hardening program. On 09/06/07 and 09/13/07, Dr. wrote preauthorization requests for xx sessions of work hardening. On xx/xx/xx, Dr. wrote a letter of approval for xx sessions of work hardening only. Work conditioning was performed with Dr. from xx/xx/xx through xx/xx/xx for a total of xx sessions. On xx/xx/xx, Dr. performed a neurolysis injection to the right lower extremity. On 10/02/07, Dr. wrote a request for an additional xx sessions of work hardening. On xx/xx/xx, Dr. wrote a request for an additional xx sessions of work hardening. On 10/23/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 6% whole person impairment rating. On 10/24/07, Dr. wrote a letter of non-certification for further work hardening. On 10/26/07, Dr. wrote a request for reconsideration letter for further work hardening. On 10/31/07 and 11/01/07, Dr. wrote a letter of denial for further work hardening. On 11/16/07, Dr. wrote a letter of reconsideration request for xx more sessions of work conditioning.

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

Based upon the supplied documentation, it appears that the patient's condition has improved, albeit gradually. Her condition has continued to improve, her pain levels have decreased, and her level of functioning has increased. Based upon the original documentation submitted, the patient's condition will require a Medium/Heavy physical demand level on a frequent basis. The patient has nearly reached that goal. I would recommend an additional 10 sessions of the work conditioning program as being medically reasonable and necessary. There are no specific guidelines detailing admission into a work conditioning program for this type of an injury but based upon the documentation, it does appear that her condition has continued to respond. I do not feel that any sessions beyond

an additional 10 sessions would be reasonable and necessary. Therefore, in my opinion, the requested Non-DWC exempt work conditioning would be reasonable and necessary.

**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)