



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 03/26/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work hardening on 10/10/06, 10/11/06, 10/12/06, 10/13/06, 10/16/06, 10/17/06, 10/18/06, 10/19/06, 10/20/06, 10/23/06, 10/24/06, 10/25/06, 10/26/06, and 10/27/06

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

Board Certified in Orthopedic Surgery
Fellowship Trained in Hand 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

A Workers' Compensation First Report of Injury or Illness form dated

An evaluation with an unknown provider (no name or signature was available) dated 06/23/06

Evaluations with, D.C. dated xx/xx/xx, 07/17/06, 08/01/06, 08/03/06, 11/02/06, 12/06/06, and 12/11/06

Chiropractic therapy with Dr. dated 07/05/06, 07/12/06, 07/19/06, 07/26/06, 08/02/06, 08/08/06, 08/14/06, 08/16/06, 08/20/06, 08/22/06, and 09/05/06

A letter of medical necessity from Dr. dated 09/21/06

An EMG/NCV study interpreted by, M.D. dated 09/22/06

Evaluations with, M.S.P.T. dated 10/06/06 and 10/31/06

Weekly progress reports from an unknown provider (no name or signature was available) dated 10/16/06 through 10/20/06 and 10/23/06 through 10/27/06

A Billing Retrospective Review from, D.O. dated 11/29/06

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. recommended chiropractic therapy three times a week for four weeks. Chiropractic therapy was performed with Dr. from 07/05/06 through 09/05/06 for a total of 11 sessions. An EMG/NCV study interpreted by Dr. on 09/22/06 was unremarkable. Work hardening weekly progress notes were provided by an unknown provider for the weeks of 10/16/06 through 10/20/06 and 10/23/06 through 10/27/06. FCEs with Ms. on 10/06/06 and 10/31/06 indicated the patient functioned at a light physical demand level. On 12/11/06, Dr. provided the patient with a 10% whole person impairment rating.

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

This patient had what I would consider moderate to even mild chronic arm pain from the injury and treatment. Normally for these cases, a short work hardening program would be necessary, especially if she did already receive physical therapy. Therefore, the work hardening (97545) on 10/10/06, 10/11/06, 10/12/06, 10/13/06, 10/16/06, 10/17/06, 10/18/06, 10/19/06, 10/20/06, 10/23/06, 10/24/06, 10/25/06, 10/26/06, and 10/27/06 would be reasonable and necessary as related to the original injury. The ODG and ACOEM do not allow for an enormous amount of work hardening for this. Therefore, I would state that the work hardening each additional hour (97546) on 10/10/06, 10/11/06, 10/12/06, 10/13/06, 10/16/06, 10/17/06, 10/18/06, 10/19/06, 10/20/06, 10/23/06, 10/24/06, 10/25/06, 10/26/06, and 10/27/06 would not be reasonable or necessary as related to the original injury.

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 AND KNOWLEDGE BASE**
- 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)**