PROFESSIONAL ASSOCIATES

DATE OF REVIEW: 05/11/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of work hardening five times a week for two weeks (97545-WH, 97546-WH)

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)

X 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

An operative report from, M.D. dated 07/24/06
Functional Capacity Evaluations (FCEs) with, D.C. dated 12/07/06 and 03/29/07
A Notice of Independent Review Decision from, M.D. at Institute dated 02/16/07
A Designated Doctor Evaluation with, D.O. dated 02/22/07

Work hardening with, D.C., Dr., L.C.S.W. dated 03/12/07, 03/13/07, 03/14/07, 03/15/07, 03/19/07, 03/20/07, 03/21/07, 03/22/07, 03/26/07, and 03/27/07
Progress notes from an unknown provider (signature was illegible) dated 03/13/07, 03/19/07, and 03/27/07
Interdisciplinary team weekly meetings with Ms. and Dr. dated 03/15/07, 03/22/07, and 03/27/07
A request letter from Dr. dated 04/05/07
A letter of denial from, L.V.N. at dated 04/10/07
A request for reconsideration from Dr. dated 04/12/07
A letter of denial from, D.C. at dated 04/19/07
A medical dispute for a work hardening program from Dr. dated 04/24/07
A letter of non-authorization from, R.N. at dated 04/25/07

PATIENT CLINICAL HISTORY [SUMMARY]:

On xx/xx/xx, Dr. performed left knee surgery. An FCE with Dr. on xx/xx/xx indicated the patient functioned at the light physical demand level and 10 sessions of a work hardening program were requested. On 02/22/07, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 4% whole person impairment rating. Work hardening was performed with Dr., Dr., and Ms. from 03/12/07 through 03/27/07 for a total of 10 sessions. Another FCE with Dr. on 03/29/07 revealed the patient functioned at the light medium physical demand level and 10 more sessions of a work hardening program were requested. On 04/05/07, Dr. wrote a request for additional work hardening. On 04/10/07, Ms. wrote a letter of non-certification for further work hardening. On 04/12/07, Dr. wrote a request for reconsideration for work hardening. On 04/19/07, Dr. wrote a letter of non-certification for further work hardening. On 04/24/07, Dr. provided a medical dispute. On 04/25/07, Ms. stated the carrier maintained its position of non-certification.

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

Based upon the supplied documentation, it appears the patient's condition has continued to respond to the work hardening program as substantiated by the Functional Capacity Evaluation. The patient has continued to demonstrate increased range of motion, and his physical demand level has continued to increase. The patient has not reached his job-required physical demand level of medium-heavy. Although they are allowing him to function at a light job demand level at the current time, it is for a temporary basis. Therefore, an attempt needs to be made to assist the patient in reaching his job specific physical demand level so that he may return to full duty. All documentation provided appears the patient is progressing as expected. Work hardening is necessary versus work conditioning as it appears the patient has demonstrated a history of depression secondary to his work-related injury. Therefore, the multidisciplinary approach

provided by work hardening would be medically reasonable and appropriate for this patient's injury.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- X **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**
- X **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)**