

Notice of Independent Review Decision

**IRO REVIEWER REPORT**

**DATE OF REVIEW:** 04/29/08

**IRO CASE #:**

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

Work Conditioning X 20 sessions

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

The TMF physician reviewer is a board certified orthopedic surgeon with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

**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.

It is determined that the proposed work conditioning X 20 visits is not medically indicated.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Report of functional capacity evaluation – 03/27/08

- Office visit notes with foot function index progress reports, ankle scoring scale progress reports, and AAOS left lower extremity ROM progress reports from Therapy – 01/08/08, 01/18/08, 02/22/08
- Daily treatment notes from Therapy – 01/08/08 to 02/20/08
- Letter from Therapy to PAC – 01/18/08
- Outpatient History and Physical examination with plan of care – 01/08/08
- Notice to Utilization Review Agent of Assignment of IRO – 04/21/08
- Letter of Determination – 04/04/08,04/14/08
- Information for requesting a review by an IRO – 04/18/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/xx resulting in a crush injury to the left foot with complaints of left lower foot pain and numbness. The patient has been treated with physical therapy.

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

The medical record documentation offers no clear description of the mechanism of the injury. The only medical information submitted is present in the physical therapy notes and functional capacity evaluations. There is insufficient information present to justify work hardening or conditioning. The ODG 2008, Low Back Chapter p. 925 has criteria for inclusion in work hardening programs. There is no medical information submitted to suggest that this patient meets criteria.

**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)