Clear Resolutions Inc.

An Independent Review Organization
7301 Ranch Rd 620 N, Suite 155-199
Austin, TX 78726
Fax: 512-519-7316

Notice of Independent Review Decision

DATE OF REVIEW: **AUGUST 13, 2008**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work conditioning program five times a week for two to four weeks.

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

M.D., Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity does not exist for work conditioning program five times a week for two to four weeks.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Peer review, Dr. 05/27/08
Peer review, Dr. 06/09/08
ODG Guidelines and Treatment Guidelines
Initial visit, Dr. 11/27/07
MRI lumbar spine, 12/05/07

Clinic notes, 10/09/07, 10/23/07, 12/04/07, 12/13/07,12/17/07,01/?/08,01/22/08, 02/07/08, 02/21/08,03/06/08, 03/13/08, 04/03/08, 04/10/08, 05/13/08, 06/12/08, 06/19/08, undated
EMG/NCV, 01/18/08
Physical therapy notes, 01/03/08, 02/14/08
Physical therapy evaluation, 10/16/07
FCE, PT, 04/15/08, 06/24/08
Letter, Dr. 05/19/08, 05/29/08
Therapy order sheets, 10/09/07, 10/23/07, 12/17/07, 01/03/08, 03/13/08, 04/03/08
FCE request, 04/10/08
Status report, 04/17/08, 04/24/08, 07/01/08
Work conditioning requests, 05/05/08, 06/17/08

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female with a date of injury of xx/xx/xx. She sustained a work fall with injury to her head, neck and back. A nerve conduction study and electromyelogram of 01/18/08 showed left hip and radicular leg pain. A physical therapy note of 01/03/08 stated the claimant had completed 12 sessions at another facility. A functional capacity exam was done on 04/15/08 and on 06/24/08. The 06/24/08 exam found the claimant tolerated a sedentary light level which was an improvement from the previous level. Dr.'s letter of 05/29/08 stated the claimant had made significant improvement in the work conditioning program, she had completed ten sessions. The diagnoses were cervicothoracic sprain/strain, multilevel cervical stenosis, cervical disc protrusion, right hip strain/sprain, and right knee internal derangement syndrome.

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

Review of the medical records provided would not support that the claimant meets the Official Disability Guideline criteria for readmission to a work hardening program. There is no defined return to work or job demands that exceed her abilities at this time, and there is no documented on the job training. She has successfully completed a rehabilitation program of work hardening and work conditioning.

Thus, per Official Disability Guideline #10, it is not medically warranted for the claimant's condition. The reviewer finds that medical necessity does not exist for work conditioning program five times a week for two to four weeks.

(Official Disability Guidelines Treatment in Worker's Comp 2008 Updates. Website, neck, work conditioning.)

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)**