

Applied Resolutions LLC

An Independent Review Organization
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Notice of Independent Review Decision

DATE OF REVIEW: SEPTEMBER 4, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 sessions of work hardening

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

A Chiropractor 12 years of treating patients in the Texas Workers' Compensation system as a level II approved treating doctor

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

OD Guidelines
Denial Letters 6/24/08 and 7/29/08
Records from 5/2/08 thru 7/7/08; FCE 6/9/08
Record from 7/28/08
Records from 5/16/08 and EMG 3/10/08
Record from 5/12/08
Records from 2/6/08 thru 5/5/08
Record from Dr. 4/8/08
MRI 3/5/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on while working in a warehouse rolling cable wire. Each roll weighs about 20-30lbs. On the day of her injury, she was rolling cable wire with her right hand and guiding the wire with the left hand. As she was rolling it, the roll got stuck and she pulled hard on the roll to free it, experiencing neck and upper back pain.

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

The 10 sessions of work hardening are not reasonable or medically necessary according to the below referenced criteria. It appears that the injured employee is able to meet her PDC of her job, which would rule out the need for work hardening. Also, there appears to be no psychological areas to address which would again rule out the need for work hardening. Therefore, the 10 sessions of work hardening are not reasonable or medically 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)**