



Specialty Independent Review Organization

**Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/17/09

**IRO CASE #:**

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

The services under dispute include a work conditioning program 8 hours per day for 10 days.

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

The reviewer is a Doctor of Chiropractic who has been practicing for greater than 15 years. The reviewer has performed his type of service in daily practice.

**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)

The reviewer agrees with the previous adverse determination regarding all services under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Records were received and reviewed from the following parties:

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**PATIENT CLINICAL HISTORY [SUMMARY]:**

The patient was injured on or about xx/xx/xx while employed . He measures 5'7" and weighs xxx pounds. The records indicate he injured his left knee while pulling a pallet of floor tile. The MRI in May of 2008 indicated a normal reading. He had surgery in September of 2008 which consisted of chondroplasty due to grade 2/3 chondromalacia and synovectomy. Other treatments have been conservative in nature. A second MRI in February of 2009 indicates bone edema to be present without significant chondral or ligamentous injury.

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

## **DECISION.**

The ODG notes that WC is recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. ([Schonstein-Cochrane, 2003](#)) There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. ([Karjalainen, 2003](#)) Work Conditioning should restore the client's physical capacity and function. The ODG criteria for a work conditioning program include the following: WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs).

The reviewer has reviewed the available documentation and indicates that the rehabilitation records for this patient have not sufficiently documented improvement objectively. It is unlikely that further rehabilitative protocols will help this patient who is approximately 19 months post injury. The MRI reports do not indicate a treatable condition through a work conditioning program. Lastly, this gentleman does not have a job to return to at this time. The request indicates he must be at a medium PDL but with no job to return to this statement could be questioned. He could likely function at a lower PDL according to the provided PPE reports.

Based upon the records provided and the patient's treatment history and current presentation, the requested program is found to not be medically necessary at this time.

**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)