



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
Fax: 715-552-0748  
Independent.Review@medworkiro.com  
[www.medwork.org](http://www.medwork.org)



*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*  
*Workers' Compensation Health Care Non-network (WC)*  
*MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 08/17/2010**

**IRO CASE #:**

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

Work conditioning 3 x week x 3 weeks

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

Texas State Licensed DO Board Certified Physical Medicine & Rehab physician

**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**

1. Texas Dept of Insurance Assignment to Medwork 08/02/2010
2. Notice of assignment to URA 08/02/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 08/02/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 07/30/2010
6. letter 07/28/2010, 06/29/2010, letter 07/27/2010, peer/peer review 07/27/2010, medical note 07/16/2010, pre-auth fax rqst 06/23/2010, FCE 06/16/2010, job descript
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

The claimant is a who sustained a cervical/lumbar sprain and strain injury, while performing usual occupational duties on xx/xx/xx. The in which she was working, resulting in the occupational injury. The claimant underwent 6 physical therapy treatment sessions. The treating physician then prescribed work conditioning 3 times a week for 3 weeks because the June 16, 2010 functional capacity evaluation determined that the claimant is capable of light/medium physical demand level. However, her usual occupational duties as a require a heavy physical demand level.



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

The ODG requires a valid baseline functional capacity evaluation prior to the initiation of a work conditioning program in order to determine the outcome of this particular program. In review of the records presented the claimant has not exhausted conventional physical therapy treatment for this work injury; therefore; the insurer's denial for the requested work conditioning program 3 x week x 3 weeks is upheld. The claimant did not undergo the maximum number of 10 physical therapy sessions allowed for cervical/lumbar sprain/strain injuries, according to official disability guidelines. The functional capacity evaluation dated June 16, 2010 is incomplete, as several types of lifting activities were not performed for unexplained reasons including the high, far, and near lifts, along with the leg lift. There was also evidence of submaximal performance, such as the CV (coefficient of variation) of the left hand, Chuck pinch strength as 18.2%. The work conditioning program is not recommended because the functional capacity evaluation of June 16, 2010 is incomplete, and demonstrates an element of submaximal effort of the claimant.

### **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)