



MedHealth Review, Inc.
661 E. Main Street
Suite 200-305
Midlothian, TX 76065
Ph 972-921-9094
Fax 972-775-6056

Notice of Independent Review Decision

DATE OF REVIEW: 11/04/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of an 80 hour work hardening program.

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 is board certified in Rehabilitation. The reviewer has practiced for greater than 15 years in this field.

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 disagrees with the previous adverse determination regarding the prospective medical necessity of an 80 hour work hardening program.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Medical Healthcare (DMH) and.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 10/6/10 letter by DC, 10/18/10 IRO letter, SOAP notes by 7/19/10 to 9/20/10, 6/24/10 initial medical report by, 8/31/10 letter by 8/30/10 mental health evaluation, 2/18/10 operative report, 8/12/10 report by MD, OT notes 4/22/10, 7/23/10 left hand MRI and x-ray report, FCE report of 8/31/10 and a ROM/MMT test of 6/28/10.

Carrier: 9/20/10 request for WH letter, 9/22/10 request for recon letter, OT flow sheet 3/17/10 to 4/22/10, 2/18/10 to 4/14/10 progress notes by MD, OT progress notes 4/13/10, 9/15/10 denial letter, 9/16/10 denial letter, 8/17/10 letter by Dr., 9/9/10 LMN for WH, ODG guide analysis for 70988, SOAP notes from 6/24/10 to 9/20/10, DD report and DWC 69 by MD and 9/29/10 denial letter with report.

A copy of the ODG was provided by the Carrier/URA for this review.

PATIENT CLINICAL HISTORY (SUMMARY):

This patient is a male who was injured while working for xxxx. He measures 6'2" and weighs 230 pounds according to the records. He was injured when his hand was caught between a rope and a cat eye. He sustained a traumatic amputation of the left 4th digit distal phalange as well as fractures to the 3rd and 5th digits of the same hand. He was treated surgically and followed with occupational therapy and chiropractic care.

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

The following are the ODG requirements for approval of a WH program. (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). This criterion is met.

(2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. This criterion is met.

(3) Not a candidate where surgery or other treatments would clearly be warranted to improve function. This criterion is met.

(4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. This criterion is met.

(5) A defined return to work goal agreed to by the employer & employee:

(a) A documented specific job to return to with job demands that exceed abilities; This criterion is met based upon the 8/31/10 letter by.

OR

(b) Documented on-the-job training

(6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. This criterion has been met

(7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. This criterion is met.

(8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. This criterion is met.

(9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. This criterion is met.

(10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. This criterion is met.

This gentleman's medical records indicate that he has met all 10 of the current requirements required by the ODG. His new job with MJM Mechanical Services indicates he will be required to be in the medium PDL category. Secondary to all requirements being met, the requested service is found to 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)**