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An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Apr/08/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening 5 x wk x 2 wks for the right wrist

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

MD, Board Certified Physical Medicine and Rehabilitation and Pain Management

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)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Utilization review determinations dated 02/28/11, 03/17/11

Preauthorization request dated 02/21/11

Industrial rehabilitation comprehensive care plan

Functional capacity evaluation dated 12/02/10

Psychological diagnostic interview dated 01/31/11

Official Disability Guidelines, Pain Chapter, Work Conditioning, work hardening

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient fell at work and sustained a right distal radius fracture that required operative intervention. Functional capacity evaluation dated 12/02/10 indicates that the patient's current PDL is sedentary and required PDL is medium. Treatment to date is noted to include surgical intervention, pharmacologic management and passive/active physical therapy. Psychological diagnostic interview dated 01/31/11 indicates that BDI is 11 and BAI is 6. The patient is currently taking Vicodin 5/500 mg every 4-6 hours as needed. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. Initial request for work hardening was non-certified on 02/28/11 noting that the physical therapy notes provided for review do not indicate the patient reached a plateau with therapy. The functional capacity evaluation revealed significant elevated FABQ scores that were also noted on the behavioral evaluation. Given these possible psychosocial indicators for delayed recovery, there could be other programs that should be completed prior to a work hardening program. No specific return to work plan was provided for review. The denial was upheld on appeal on 03/17/11 noting that the patient's elevated FABQ scores would indicate a potential for delayed progress in a program the intensity of a work hardening program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS

AND CONCLUSIONS USED TO SUPPORT THE DECISION

Based on the clinical information provided, the reviewer finds that work hardening 5 x wk x 2 wks for the right wrist is not medically necessary. There are no records to establish that the patient has undergone an adequate course of physical therapy with improvement followed by plateau. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient presents with elevated FABQ scores on functional capacity evaluation and behavioral evaluation; however, there is no indication that the patient has undergone a course of individual psychotherapy. There is no specific, defined return to work goal provided. Given this data, upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

ACOEM-AMERICA 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)