

SENT VIA EMAIL OR FAX ON
Dec/16/2011

P-IRO Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Dec/15/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Additional hours work hardening program

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine & Rehab and Pain Medicine

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

OD Guidelines

Cover sheet and working documents

Utilization review determination dated 10/19/11, 11/09/11

Work hardening program preauthorization request dated 10/14/11

PPE dated 10/03/11

Reassessment for work hardening program continuation dated 10/05/11

Preauthorization determination letter dated 09/19/11

Reconsideration dated 11/04/11

Functional capacity evaluation dated 09/07/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. The patient sustained a crush injury to his left hand ring finger when it was crushed between a pallet of metal pipes and the forks of a forklift. The patient underwent surgical intervention on 01/21/11 followed by postoperative physical therapy. Functional capacity evaluation dated 09/07/11 indicates that the patient has completed 10 sessions of work hardening to date. Required PDL is heavy and current

PDL is medium. PPE dated 10/03/11 indicates that current PDL remains medium. Reassessment for work hardening program continuation reports that pain increased from 3 to 4/10. Subjective reports of irritability, muscle tension, anxiety and depression slightly improved while frustration and sleep problems remained the same. Medications include Diclofenac sodium and Carrasyn gel. BDI decreased from 5 to 3.

Initial request for work hardening was non-certified on 10/19/11 noting that the patient's functional capacity evaluation is consistent with submax and/or inconsistent effort. Even with submaximal effort the patient is performing at least medium heavy work and there is no medical indication for additional work hardening. The denial was upheld on appeal dated 11/09/11 noting that there have not been sufficient functional gains to support ongoing participation in the requested 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 request for additional hours work hardening program is not recommended as medically necessary, and the two previous denials are upheld. The patient has completed 80 hours of work hardening to date without significant functional progress. The patient's physical demand level remained unchanged at medium. There is some evidence that the patient provided submaximal and/or inconsistent effort on functional capacity evaluation. Reassessment for work hardening program continuation reports that pain increased from 3 to 4/10. Subjective reports of irritability, muscle tension, anxiety and depression slightly improved while frustration and sleep problems remained the same. Medications include Diclofenac sodium and Carrasyn gel. BDI decreased from 5 to 3 which is in the normal range. The Official Disability Guidelines support up to 160 hours of work hardening with evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Given the lack of documented subjective and objective improvement, the requested work hardening is not indicated as medically necessary.

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)