

SENT VIA EMAIL OR FAX ON
May/02/2011

Applied Assessments LLC

An Independent Review Organization

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Apr/28/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning program 10 days or 80 hours

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

Board Certified Chiropractic Examiner

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

PATIENT CLINICAL HISTORY SUMMARY

The patient's date of injury is xx/xx/xx. On this date the patient felt a pop and pain. MRI of the thoracic spine dated 09/20/10 revealed slight annular bulging/tiny disc protrusions at several levels. Functional capacity assessment dated 03/08/11 indicates that the patient's required PDL is medium/heavy and current PDL is medium. Functional restoration program assessment dated 03/08/11 indicates that the patient underwent physical medicine treatments which increased his pain and underwent injection therapy as well.

Initial request for work conditioning program 10 days or 80 hours was non-certified on 03/29/11 noting that there is no job description provided from the patient's employer outlining job duties or lifting requirements. The designated doctor examination made no recommendations for work conditioning, but instead stated that the patient was ready to return to regular work duties. The denial was upheld on appeal dated 04/06/11 noting no

significant clinical findings or cognitive dysfunction. There is no job description submitted for review.

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 work conditioning program 10 days or 80 hours is not recommended as medically necessary. The patient sustained injury on xx/xx/xx; however, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. There is no job description submitted for review outlining the patient's job duties or lifting requirements. The patient underwent previous designated doctor evaluation that did not recommend work-conditioning program, but instead reported that the patient was ready to return to work at regular duty. Given the current clinical data, the requested work conditioning is not indicated as medically necessary, and the two previous denials are 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)