

# Pure Resolutions Inc.

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

### DATE OF REVIEW:

Oct/06/2011

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning 5 X wk X 2 wks or 30 hours, right wrist

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

Orthopedic Surgery

### 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 08/09/11, 08/17/11

Letter of medical necessity dated 09/14/11

Orders dated 07/20/11

Functional capacity evaluation dated 08/02/11

Letter undated

Handwritten note dated 06/24/11, 08/10/11

Physical therapy initial evaluation dated 08/02/11

### PATIENT CLINICAL HISTORY SUMMARY

The patient is a male whose date of injury is xx/xx/xx. On this date the patient was working 30 ft from the ground, coming down when he slipped and fell. The patient sustained a distal radius fracture and underwent surgery followed by 27 postoperative physical therapy sessions. Physical therapy initial evaluation dated 08/02/11 notes that the patient has minimum to no pain. He has some limitations with his wrist with extension and flexion. Functional capacity evaluation dated 08/02/11 indicates that the patient is not currently taking any medications. The patient's current PDL is heavy.

Initial request for work conditioning was non-certified on 08/09/11 noting that the request was for 20 sessions and the request exceeds ODG recommendations. The denial was upheld on appeal dated 08/17/11 noting that the functional capacity evaluation did not indicate required PDL. The PT progress notes did not indicate that the patient's clinical and functional

response to therapy has plateaued. There is no documentation ruling out any psychosocial/behavioral problems that can interfere with functional progress with work conditioning.

**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 5 x wk x 2 wks or 30 hours, right wrist is not recommended as medically necessary, and the two previous denials are upheld. The submitted functional capacity evaluation indicates that the patient's current PDL is heavy; however, required physical demand level for return to work is not documented. There is no comprehensive assessment of the patient's objective, functional response to physical therapy completed to date submitted for review to establish efficacy of treatment and/or functional plateau. Given the current clinical data, the requested work conditioning 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)