INDEPENDENT REVIEW INCORPORATED

Notice of Independent Review Decision

REVIEWER'S REPORT

DATE OF REVIEW: 04/07/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work hardening program X 80 hours (97545, 97546)

DESCRIPTION OF QUALIFICATIONS OF REVIEWER:
M.D., practicing in the State of Texas for greater than 35 years, board certified in the ABMS specialty of Physical Medicine and Rehabilitation

REVIEW OUTCOME:
Upon independent review, I find that the previous adverse determination or determinations should be:

_____ Upheld (Agree)

__X__ Overturned (Disagree)

_____Partially Overturned (Agree in part/Disagree in part)

The requested services for review consist of an initial 80 hours of work hardening. The determination following review of the medical records provided indicate that the services being requested are medically reasonable and necessary according to the ODG criteria.

Primary Diagnosis Code	*Service Being Denied*	*Billing Modifier*	*Type of Review*	*Units*	*Date(s) of Service*	*Amount Billed*	*Date of Injury*	*DWC Claim #*	*Upheld Overturn*
836.0	*97545*		*Prosp.*				*09/27/11*	*WC2005590*	*Overturn*

INFORMATION PROVIDED FOR REVIEW:
1. Certification of independence of the reviewer and TDI case assignment
2. case assignment
3. Letters of denial, 02/28/12 and 03/12/12, including the criteria used in the denial
4. Request for preauthorization, 02/23/12, and request for reconsideration, 03/02/12
5. Rationale for request, 03/09/12
6. Initial Behavioral Medicine consultation, 02/17/12
7. Report of Work Duties, 02/17/12
8. PPE, 02/22/12
9. Multidisciplinary work hardening plan and goals of treatment, 02/19/12

INJURED EMPLOYEE CLINICAL HISTORY (Summary):
According to the provided medical documentation, this individual had been employed at this job for approximately x years when the injury occurred. She indicated that while working. She reports slipping and falling onto her right side, striking the right shoulder, arm, and knee. She noted that she was unable to get for a period of time due to the knee pain on the right. She finished her shift, as there were no other managers available to replace her for her shift. She sought treatment on 09/29/11, as there had been no available replacement for her shifts. She underwent x-rays and MRI scan of the right elbow, shoulder, and knee. She participated in physical therapy.

She continued to work up until the time of her surgery on 12/06/11. She participated in physical therapy postoperatively with eighteen treatment sessions. The recommended ODG postoperative treatment of physical

therapy for a meniscal surgery is twelve treatment sessions. The patient with recent PPE does not meet release for return to work at her full job level. She does have a job to return to with her former employer.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:

This patient has exceeded the post surgical number of physical therapy treatments based on the ODG criteria. She has not reached her physical demand level for unrestricted release to work, which is at least a medium level. As the patient has exceeded the ODG criteria for post surgical physical therapy, the progression, based on the ODG, would be for work hardening. An initial 80 hours with re-evaluation is appropriate based on the ODG.

DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR 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 judgment, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X __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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)