

US Decisions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

WH, 5 x 2 weeks (10 sessions)

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

M.D., Board Certified 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

Official Disability Guidelines & Treatment Guidelines

MRI knee without contrast 10/13/11

Initial evaluation and follow-up notes D.C. 10/18/11-03/16/12

Operative report 12/08/11 for right knee arthroscopic partial lateral meniscectomy with tricompartmental lavage and chondroplasty

Follow-up notes Dr 01/26/12-03/16/12

Functional capacity evaluation 03/15/12

Utilization review determination 04/19/12

Utilization review determination 05/04/12

PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male with complaints of right knee pain following a work related injury on xx/xx/xx. MRI of the right knee performed 10/13/11 revealed lateral predominant tricompartmental degenerative changes. There was an extensive lateral meniscal tear noted. There were degenerative changes involving the medial meniscus without distinct medial meniscal tearing to an articular surface. The claimant underwent right knee arthroscopic partial lateral meniscectomy with tricompartment lavage and chondroplasty on 12/08/11. A functional capacity evaluation performed 03/15/12 placed the claimant in the medium physical demand level, while the claimant's occupation required a heavy physical demand level. Behavioral health evaluation performed 03/16/12 revealed a FABQ-PA score of 14 and a FABQ-W score of 25, indicating moderate clinical fear avoidance issues.

The claimant saw Dr. on 03/16/12 with complaints of mild tenderness of the right knee despite post-operative physical therapy. Physical exam revealed flexion to 111 degrees. There was full extension and no evidence of instability. There was a mild degree of elevated medial joint pain with valgus stress. The claimant ambulated with a normal gait. There was

mild weakness of flexion and extension of the knee, related to endurance. The claimant was recommended for 10 sessions of work hardening. The request for work hardening was denied by utilization review on 04/19/12 due to no evidence of significant psychological issues to support the request. There was no evidence that the claimant had reached a plateau with the physical therapy provided. There was no evidence of attempts to return to modified work duties or full duty work status. There was no written job verification from the employer, nor was there a job description provided for review. The request for work hardening was denied by utilization review on 05/04/12 as there was no evidence of depression or anxiety. The claimant had already exceeded the Best Return to Work Guidelines and time frame for his work injury. There was no evidence the claimant was working modified or restricted duty. The claimant met the medium physical demand level, just under the heavy physical demand level.

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

There is no clinical evidence from the physical therapy summary reports that this claimant has reached a plateau with standard therapy. The clinical documentation does not discuss any return to work issues and does not provide a return to work agreement between the claimant and employer. It is unclear from the clinical notes what the claimant's work restrictions were or if the claimant was unable to continue working with restrictions. As the clinical documentation provided for review does not meet guideline recommendations for the proposed work hardening program, the reviewer finds medical necessity is not established for WH, 5 x 2 weeks (10 sessions). 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)