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Notice of Independent Review Decision

DATE OF REVIEW: 5/7/12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of work hardening x 10 sessions; 80 hours.

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. The reviewer has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of work hardening x 10 sessions; 80 hours.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: and Rehab.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from: 4/19/12 letter by, 4/19/12 IRO summary report, 6/12/11 DWC form 1, 6/11/11 request for WC care, 6/11/11 associate statement, 6/12/11 to 6/18/11 bona fide job offers, 6/12/11 notes from xxxx, various DWC 73 forms, 6/13/11 to 12/15/11 exam notes from xxxx, 6/16/11 to 3/14/12 exam notes from xxxx (xxxx), 7/6/11 right knee MRI report, 7/13/11 to 10/26/11 US toxicology reports, 7/14/11 to 10/31/11 daily notes from AH, 9/16/11 operative report, 11/2/11 to 1/23/12 lab reports from Physicians

choice, 11/2/11 PPE report, 12/15/11 FCE report, 12/29/11 to 2/17/12 Spanish work conditioning notes, exercise flowsheet 12/26/11 to 2/17/12, WC weekly progress, treatment plans, goals and notes, 2/20/12 FCE report, 3/1/12 initial inclinometry report, 3/1/12 SOAP notes from xxxx xxxx, 3/21/12 arthrography and radiographic reports, 2/29/12 denial letter, 2/24/12 precert request with letter, 3/27/12 denial letter, and 3/19/12 appeal request with letter.

N. TX Rehab: All records submitted were duplicative of those sent above.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

This employee is with a date of birth of xx/xx/xx. He reported an injury to the right knee on 6/11/2011 after striking the knee on an extendable shelf and also twisting the knee. He was working at as a classified as. Initially he was diagnosed with a strain and went on to have anterior/posterior cruciate repair, partial medial and lateral meniscectomy, synovectomy abrasion arthroplasty and removal of adhesions. He has had 25 PT visits and 30 work conditioning treatments of 90 hours. He has improved to a medium level PDL but continues to be unable to squat to floor and has endurance issues as well as continued difficulty standing and weakness on right side. There is a request for work hardening.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS. FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

This claimant has had extensive treatment for his injury. His treatment has included physical therapy, surgery and work conditioning. Upon completion of a rehabilitation program (work conditioning, work hardening, outpatient medical rehabilitation or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. (ODG guidelines; work conditioning/ work hardening; TWC PAIN) Due to the above criteria, the ODG does not support the requested treatment. Therefore, it is found to be not medically necessary at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE 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 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)**