

Applied Resolutions LLC

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/31/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening X 2 weeks

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

Board Certified PM&R
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)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Cover sheet and working documents
Utilization review determination dated 07/19/12, 08/07/12
Office visit note dated 06/18/12, 07/02/12, 07/16/12, 06/04/12, 05/21/12, 04/30/12, 04/11/12, 04/03/12, 03/21/12, 03/07/12, 02/22/12, 02/08/12, 01/25/12, 01/11/12, 12/28/11, 12/20/11
Functional capacity evaluation dated 07/12/12
Initial diagnostic screening dated 06/22/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. On this date the patient injured her right thumb, index finger and back of the right wrist. Note dated 12/20/11 indicates that treatment to date includes physical therapy and nerve conduction study. The patient has a history of surgeries to include bilateral carpal tunnel release, right ulnar nerve release and a fracture of the right wrist. Note dated 01/11/12 indicates that the patient underwent injection and notes that it helped. Psychological evaluation dated 06/22/12 indicates that the patient underwent right thumb and index trigger finger release as well as decompression of the radial sensory nerve on 03/27/12 followed by 12 postoperative physical therapy visits. Current medications are Ibuprofen and Vicodin. BDI is 16 and BAI is 12. Diagnoses are adjustment disorder unspecified and pain disorder associated with work related injury medical condition and psychological factors. Functional capacity evaluation dated 07/12/12 indicates that current PDL is light and required PDL is light.

Initial request for work hardening x 2 weeks was non-certified on 07/19/12 noting that the functional capacity evaluation notes that the employee is at a light PDL; however, the actual values indicate employee has reached the medium PDL which surpasses her work required PDL. The denial was upheld on appeal dated 08/07/12 noting that the employee has already surpassed her work required PDL and the request does not comply with ODG.

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

Based on the clinical information provided, the request for work hardening x 2 weeks is not recommended as medically necessary, and the two previous denials are upheld. The submitted functional capacity evaluation indicates that the patient's required physical demand level for return to work is light, and the actual values on the report indicate that the patient has reached the medium physical demand level which surpasses her work required PDL. The Official Disability Guidelines note that a valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Therefore, the requested work hardening program 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)