

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Nov/26/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 hours of Work Hardening Program

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

PM&R

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
Utilization review determination dated 10/07/13, 11/07/13, 02/15/13, 06/11/13
Physical therapy initial evaluation dated 02/11/13
Request for reconsideration dated 10/08/13
Preauthorization request dated 10/02/13
Office note dated 08/30/13, 08/06/13, 04/17/13, 04/23/13
Soap note dated 08/28/13, 08/26/13, 08/22/13, 08/21/13, 08/02/13, 08/01/13, 07/29/13, 07/26/13, 07/24/13, 07/23/13, 07/18/13
Initial narrative report dated 06/04/13
Functional capacity evaluation dated 09/23/13
Diagnostic interview dated 09/26/13
Radiographic report dated 03/29/13, 10/31/12
MRI lumbar spine dated 06/08/13
MRI left shoulder dated 03/04/13
Peer review dated 04/03/13
Designated doctor evaluation dated 07/24/13, 03/18/13
Physical activity status report dated 04/23/13, 03/29/13, 10/31/12
Physical therapy re-evaluation dated 07/02/13
Employer's first report of injury or illness dated 01/27/12
Handwritten note dated 10/31/12, 01/17/13, 01/31/13, 02/13/13, 03/06/13, 03/19/13
Encounter report dated 03/29/13, 04/09/13

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a female whose date of injury is xx/xx/xx. Compensable injury is listed as contusion to the right hip and buttocks which resolved in xx/xxxx. No treatment is reasonable, warranted, necessary or appropriate regarding the compensable injury of xx/xx/xx. Physical therapy re-evaluation dated 07/02/13 indicates that diagnoses are lumbar and ankle sprain and cervical strain. Designated doctor evaluation dated 07/24/13 indicates that the patient has completed 10 sessions of physical therapy. The patient reached MMI on 02/08/12 for lower extremity contusion with 0% whole person impairment. Functional capacity evaluation dated 09/23/13 indicates that required PDL is medium and current PDL is light. Current medications are listed as ibuprofen, Tramadol and Gabapentin. Initial interview dated 09/26/13 indicates that BDI is 26 and BAI is 22. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. Preauthorization request dated 10/02/13 indicates that the patient no longer has a job.

Initial request for 80 hours of work hardening program was non-certified on 10/07/13 noting that the patient was fired from her job and is not currently working. There is no referral from a physician or nurse case manager and there is no information regarding what physician prescribes her current medications and who will manage these medications. There is lack of specific, established return to work or job plan. The denial was upheld on appeal dated 11/07/13 noting that the only accepted injuries are a right hip contusion and buttocks contusion and employee is now almost xx months post injury. A contusion injury is self-limiting and generally resolves in a matter of weeks and the patient has already exceeded this time frame. No explanation has been given as to how the current request is related to the original work injury and no objective barriers have been identified which would have prevented the natural resolution of this injury within the past xx months.

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

Injury is listed as contusion to the right hip and buttocks which resolved in xx/xxxx. No treatment is reasonable, warranted, necessary or appropriate regarding the injury of xx/xx/xx. The submitted records indicate that the patient has been terminated, and there is no specific return to work plan documented. The patient does not have a job to return to at this time. As such, it is the opinion of the reviewer that the request for 80 hours of work hardening program is not recommended as medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES