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An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Jan/29/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning X 10 sessions (5 X 2 weeks)

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

PM&R and 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:

ODG - Official Disability Guidelines & Treatment Guidelines
Functional capacity evaluation dated 12/06/12
Letter of appeal dated 01/07/13
Previous utilization reviews dated 12/13/12 and 12/21/12
Cover sheet and working documents

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury regarding his low back when he was involved in a motor vehicle accident. The functional capacity evaluation dated 12/06/12 details the patient having undergone a battery of evaluations. The patient was noted to have performed at a light physical demand level. However, the patient's occupation requires a medium physical demand level. The patient is noted to have demonstrated inconsistent findings indicating an inconsistent effort through some of the evaluation to include the NIOSH testing for strength. The clinical note dated 01/07/13 details the patient demonstrating no behavioral or medical comorbidities that preclude him from participating in a work conditioning program. The note does detail the patient continuing with musculoskeletal complaints leading to functional limitations. The patient was recommended for 40 hours of a work conditioning

program, 4 hours daily, 5 times a week for 2 weeks.

The previous utilization review dated 12/13/12 resulted in a denial secondary to a lack of information regarding the patient's completion of all conservative measures, specifically injections to rule out surgery and a lack of objective findings indicating ongoing lumbar pathology.

The utilization review dated 12/21/12 also resulted in a denial secondary to a lack of evidence indicating a valid mismatch between the patient's documented physical demand level and his required occupational physical demand level as well as an inconsistent effort rendering the functional capacity evaluation to be invalid.

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

The request for 40 hours of a work conditioning program, 4 hours daily, 5 times a week for 2 weeks is not supported as medically necessary. The documentation submitted for review elaborates the patient complaining of low back pain. The patient is noted to have completed a functional capacity evaluation; however, the patient's effort was noted to be inconsistent and this rendered the study invalid. Given the lack of consistent effort throughout the entire evaluation and taking into account the specific request for 40 hours which exceeds guideline recommendations for a work conditioning program, this request does not meet guideline recommendations. As such, the documentation submitted for this review does not support the request at this time.

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)