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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/12/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: work hardening

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Family Practice

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. It is the opinion of the reviewer that the request for work hardening is not recommended as medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The patient reports wrist pain secondary to repetitive use. Initial clinical interview dated xxxx indicates that treatment to date includes physical therapy, left wrist carpal tunnel release in October 2012, right wrist carpal tunnel release in December 2012 and March 2013, epidural steroid injections and medication management. BDI is 2 and BAI is 4. Diagnosis is pain disorder associated with both psychological factors and a general medical condition. Functional capacity evaluation dated 01/15/14 indicates that required PDL is heavy and current PDL is sedentary. Health and behavioral reassessment dated 01/27/14 indicates that the patient has completed 3 sessions of individual psychotherapy. Medications are listed as aspirin, ibuprofen, Lasix, Singulair and Tramadol. BDI is 14 and BAI is 15. Diagnoses are major depressive disorder and somatic symptom disorder.

Initial request for work hardening was non-certified on 01/30/14 noting that there is no indication that the patient has improved with previous physical therapy and the patient underwent both preoperative and postoperative physical therapy. The Official Disability Guidelines require documentation of an adequate course of physical therapy with improvement followed by plateau prior to enrollment in a work hardening program. Reconsideration request dated 02/04/14 indicates that she completed 14 postoperative physical therapy visits which the patient reports helped, but still hurt a lot. The denial was upheld on appeal dated 02/07/14 noting that there should be evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from the continuation of previous treatment which is not specified in the records provided. There are no complete therapy progress reports that objectively document the clinical and functional response of the patient from the previously rendered sessions. A valid rationale as to why the remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained repetitive use injury on xx/xx/xx and has been treated with surgical intervention to the bilateral wrists as well as preoperative and postoperative physical therapy. The submitted functional capacity evaluation dated 01/15/14 indicates that despite extensive physical therapy, the patient is only capable of performing at a sedentary physical demand level. There are no serial progress notes submitted for review documenting that the patient has completed an adequate course of physical therapy with improvement followed by plateau, as required by the Official Disability Guidelines. The patient's Beck scales actually worsened after a course of individual psychotherapy. The patient is not currently taking any opioid or psychotropic medications. As such, it is the opinion of the reviewer that the request for work hardening is not recommended 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)