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An Independent Review Organization

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DATE NOTICE SENT TO ALL PARTIES: Jan/29/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Work conditioning X12 sessions

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Orthopedic Surgery

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 conditioning x 12 sessions is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is XX/XX/XX. The mechanism of injury is described as a fall. She suffered an injury to her left wrist. She underwent a surgical procedure to her left wrist twice to repair the fractured radius. Functional capacity evaluation dated XX/XX/XX indicates that she does not have a job to return to. Current PDL is light and required PDL is medium. Encounter summary dated XX/XX/XX indicates that she has multiple concerns of aches, sharp shooting pains into the proximal forearm. Medications are listed as Ultracet and trazodone. On physical examination there is no induration, swelling or mass. There is no tenderness of the distal forearm. Active range of motion of the left wrist is flexion 80, extension 70, pronation 70, supination 80, radial motion 20 and ulnar motion 45 degrees. Lunotriquetral ballottement test, Watson's scaphoid shift test and pivot shift test of midcarpal joint are negative.

Initial request for work conditioning x 12 sessions was non-certified noting that work conditioning amounts to an additional series of intensive physical therapy visits required beyond a normal course of physical therapy primarily for exercise training and supervision. 10 visits over 4 weeks are recommended by the guidelines. This request is for 12 sessions of work conditioning. Thus the request exceeds guideline recommendations. The denial was upheld on appeal dated XX/XX/XX noting that guidelines recommend 10 visits over 4 weeks equivalent to up to 30 hours for work conditioning. The clinical documentation submitted for review indicated the patient had a left distal ulna injury and had multiple concerns of aches and shooting pain into the proximal forearm without paresthesia. On exam the patient had a grip strength of 35 pounds on the right and 50 pounds on the left. However, the request exceeds guideline recommendations for work conditioning.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries on XX/XX/XX. However, there is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The submitted records indicate that the patient underwent surgical intervention x 2 as well as physical therapy; however, there are no

operative reports or serial physical therapy records submitted for review.

The Official Disability Guidelines report that work conditioning amounts to an additional series of intensive physical therapy visits required beyond a normal course of physical therapy primarily for exercise training and supervision. Given the lack of information regarding physical therapy completed to date, the request for work conditioning is not indicated as medically necessary. Additionally, the request is excessive as the Official Disability Guidelines would support up to 10 visits/30 hours of work conditioning. As such, it is the opinion of the reviewer that the request for work conditioning x 12 sessions is not recommended as medically necessary and the prior denials are upheld.

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)