P-IRO Inc.

An Independent Review Organization
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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Conditioning Program for XXXX XX XX X XX weeks XX sessions XX hours

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

Pain Medicine, Physical Medicine & Rehab

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]:

XXXX. XXXX was diagnosed with a XX of other specified parts of the XXXX XX, subsequent encounter (XX.XX). XXXX for a follow-up of XX of the XXXX XX. XXXX stated that XXXX continued to have pain. The pain was XX/10. Inspection of the XXXX XX joint revealed XX XX. The range of motion was restricted with flexion limited to XX degrees. Movements were painful with flexion beyond XX degrees. Tenderness to palpation was noted over the XX joint line and XX. There was mild XX in the XXXX XX joint. XX gait was noted. XX XX and quad XX were prescribed. XXXX opined that work conditioning was medically necessary and would help XXXX to strengthen XXXX XX to return to XXXX previous level of function. The treatment to date included medications (XXXX), XX sessions of physical therapy with improvement, and surgery (XX repair of the XXXX XX). Per a utilization review decision letter dated XXXX and peer review dated XXXX, the requested service of work conditioning for the XXXX XX was denied by XXXX. Rationale: "Officially Disability Guidelines (ODG) for work conditioning program for the XX have not been met. Based on review of the available records, clear goals for a work conditioning program for this claimant are not documented. Specifically, review of submitted records indicates that the claimant is currently functioning at a XX physical level.

Supplied records, however, do not document what type of employment the claimant will be returning to or what the goal physical demand level will be for this claimant from work conditioning. Until these matters are clarified, a work conditioning program cannot be considered medically necessary for this claimant at this time. Therefore, the request for work conditioning program for XXXX XX XX x XX weeks XX sessions XX hours is not medically necessary." Per a utilization review decision letter dated XXXX and peer review dated XXXX, the prior decision was upheld by XXXX. Rationale: "Work conditioning can be considered appropriate per ODG criteria and may be considered when more intensive physical therapy visits are required 'beyond a normal course of physical therapy, primarily for exercise training / supervision.' The assumption of the work conditioning program would be that the patient would like to return to the previous occupation. In this case, the submitted documents are not clear whether this patient is currently working or planning on returning to the previous XX as a XXXX. A number of the documents including the functional capacity evaluation indicates the patient would like to XXXX. The notes indicate the patient is already at a sedentary physical demand level (PDL) and can tolerate sedentary activities. Given that a XXXX would likely require no more than a sedentary PDL and given that the patient is already at this functional level, it is unclear what a course of work conditioning would provide, given the patient's desire to XXXX. Therefore, the requested appeal for work conditioning program for XXXX XX XX times XX weeks XX sessions XX hours is not medically necessary."

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 conditioning for the XXXX XX, XX times per week for XX weeks, XX sessions, total XX hours is not recommended as medically necessary. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records indicate that the patient would like to XXXX. Therefore, it is unclear how a return to work program would benefit this patient at this time. As noted by the previous reviewer, a XXXX would likely require only a sedentary physical demand level which the patient is currently capable of at this time

Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the decision is upheld.

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

☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

☐ AHRQ- 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 JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

☐ MILLIMAN CARE GUIDELINES

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)

☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ PRESLEY REED, THE MEDICAL DISABILITY ADVISOR

☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

☐ TEXAS TACADA GUIDELINES

☐ TMF SCREENING CRITERIA MANUAL