
Notice of Independent Review Decision

DATE OF REVIEW: 5/7/07**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Work hardening from 5/22/06-9/8/06 (excluding 6/5/06, 6/8/06 and 6/9/06).

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

This case was reviewed by a board certified physical medicine and rehabilitation specialist on the MAXIMUS external review panel who is familiar with the condition and treatment options at issue in this appeal.

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)

| <i>Primary Dx Code</i> | <i>Service Being Denied</i> | <i>Type Review</i> | <i>DOS</i> | <i>Amt Billed</i> | <i>Date of Injury</i> | <i>DWC Claim #</i> | <i>Uphold / Overturned</i> |
|------------------------|-----------------------------|--------------------|----------------|-------------------|-----------------------|--------------------|----------------------------|
| 724.4 | 97545 | Retrospective | 5/22/06-9/8/06 | \$4200. | | | Upheld |
| 724.4 | 97546 | Retrospective | 5/22/06-9/8/06 | \$4200. | | | Upheld |

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for Independent Review by an Independent Review Organization forms – 4/5/07
2. Determination Notices – 10/4/06, 10/18/06, 11/6/06, 11/10/06, 12/8/06
3. Direct Peer Review Report – 6/16/06
4. Request for Reconsideration letter – 10/26/06, 10/30/06, 11/13/06, 12/20/06

5. Records and Correspondence from Pain Center– 2/28/06-4/25/07
6. Letter– 3/3/04
7. Peer Reviews – 6/16/06
8. Records and Correspondence from MD – 5/12/06, 10/18/06
9. Records and Correspondence from Center – 3/22/05
10. Records and Correspondence from Center – 3/21/05-11/7/05
11. Records and Correspondence from MD – 12/24/04
12. Records and Correspondence from MRI Group – 6/20/05, 1/24/06
13. Records and Correspondence from Institute – 1/12/06-1/18/07
14. Records and Correspondence from Surgical Hospital – 4/14/05-9/28/05
15. Records and Correspondence from– 9/27/05-10/17/05
16. Records and Correspondence from DC – 7/8/05-9/14/06
17. Records and Correspondence from Injured Workers Therapy Center – 3/20/05-9/6/05
18. Records and Correspondence from MD – 4/21/05-5/12/05
19. Records and Correspondence from Center – 5/5/05
20. Records and Correspondence from MD – 1/26/05-2/15/05
21. Records and Correspondence from Institute of Texas – 1/5/05-2/18/05
22. Records and Correspondence from Center – 2/8/05
23. Records and Correspondence from– 12/24/04
24. Letter of Medical Necessity – 1/19/05
25. Records and Correspondence from Medical Centers – 12/13/04-1/13/05
26. Records and Correspondence from– 4/17/06
27. Records and Correspondence from– 2/9/06
28. Evaluation Centers Report – 8/17/06, 12/7/06

PATIENT CLINICAL HISTORY:

This case concerns an adult female who sustained a work related injury. Records indicate that while mopping a kitchen floor she slipped and fell on her right knee also injuring her low back. Diagnoses have included lumbosacral neuritis, myalgia and myositis. Evaluation and treatment for this injury has included medications, active and passive physical therapy, chiropractic treatment, steroid injections and surgery.

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

This patient sustained a work related injury to her right knee and back from a fall. She was eventually found to have right knee osteoarthritis/chondromalacia and a disc protrusion with central canal and bilateral foraminal stenosis at L2-3 and right-sided osteophyte protrusion at L4-5. She underwent a functional capacity evaluation on 7/6/05 and was unable to perform at light duty. She underwent surgical treatment of the right knee with arthroscopic chondroplasty on 4/14/05 with good improvement noted by 8/8/05. On 9/8/05, she underwent an L4-5 hemi laminectomy and discectomy/foraminotomy but then developed a wound infection requiring intravenous antibiotics and inpatient care from 9/27/05-10/11/05. Other treatments have continued including epidural steroid injections and physical therapy (48 total session/31 for right knee) through 6/16/06. Treatment also included pain medications after surgery. She continued to have low back pain and right upper extremity pain. She received chiropractic care including functional capacity evaluation that reported the member had

limited active physical therapy or active exercise. It was also noted that the patient's pain level was 9/10 with radiation to the right lower extremity.

From review of the available case file documentation, the patient does not appear to have had traditional physical therapy for her low back and right lower extremity pain in an effort to improve her function. This patient was not ready for an active work hardening program with her pain level at 9/10 and she had not first had an adequate trial of active physical therapy. Review of the physical therapy records also indicates that the patient received mostly passive therapy/rehabilitation for her low back and right lower extremity pain. Therefore, it has been determined that the work hardening services from 5/22/06-9/8/06 (excluding 6/5/06, 6/8/06 and 6/9/06) were not medically necessary for treatment of the patient's condition during this time.

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
- 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)**