



Notice of Independent Review Decision

**DATE OF REVIEW:** 8/01/07

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Determine the medical appropriateness of the previously denied request for ten (10) sessions of work hardening program.

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

Chiropractic provider.

**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)

The previously denied request for

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- **Response Letter dated 7/27/07.**
- **Fax Cover Sheet dated 6/21/07.**
- **Notice to CompPartners, Inc. of Case Assignment dated 6/21/07.**
- **History/Physical Examination Report/Letter dated 7/9/07.**
- **Functional Abilities Evaluation Report dated 7/9/07.**
- **Oswestry Low Back Pain Disability Questionnaire dated 7/9/07.**
- **Neck Disability Index dated 7/9/07.**

- Pain Questionnaire dated 7/9/07.
- Pain Questionnaire dated 7/9/07.
- Report of Medical Evaluation Report dated 7/9/07.
- Letter dated 6/15/07.
- Request for a Review by an Independent Review Organization dated 6/7/06.
- Reconsideration/Appeal of Adverse Determination Letter dated 5/23/07.
- Utilization Review Determination Letter dated 4/30/07.
- Daily Progress/Procedure Note dated 3/29/07, 3/26/07, 3/20/07, 3/15/07, 3/7/07, 3/5/07, 3/1/07.
- Medical Records Request Letter dated 2/9/07.
- Discharge Instructions dated 2/8/07.
- Pelvis X-Ray dated 2/8/07.
- Emergency Department Assessment Record dated 2/8/07.
- Physician's Orders dated 2/8/07.
- Medication Reconciliation Sheet dated 2/8/07.
- Acute Care Accident Report dated 2/8/07.
- Emergency Physician Record dated 2/8/07.
- Registration Face Sheet dated 2/8/07.
- Form for Requesting a Review by an Independent Review Organization (IRO), (unspecified date).

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:**

**Gender:** Male

**Date of Injury:**

**Mechanism of Injury:** Slip and fall.

**Diagnosis:**

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

The patient is a male who sustained an injury which was described as a slip and fall resulting in lower back, mid back, and neck pain. The patient presented to the local hospital where he was evaluated and discharged. The patient then presented to the office of Dr. complaining of neck and back pain. A course of therapy was initiated. On 7/9/2007, the patient was evaluated by Dr. D.O., for the purpose of an impairment rating and maximum medical improvement (MMI) evaluation. The determination was that the patient gave a sub-maximal effort during the functional capacity evaluation (FCE) and that the PDC was indeterminate. The evaluator opined that these results may be a result of a "simple lack of effort, malingering, somatoform disorder, or self limitation secondary to pain." Dr. stated that the patient was at MMI as of 4/6/2007. Apparently, a request for work hardening was submitted in April 2007 by Healthcare Systems. This request was denied by peer review and denied on appeal. The purpose of this review is to determine the medical necessity for the requested 10 sessions of work hardening. The medical necessity for the request work hardening was not established. There were no clinical records provided regarding this request. There was no record of any functional

capacity evaluation having been performed at that time. There was no evidence of any psychosocial evaluations performed to determine if the patient had any psychosocial factors that would support a multi-disciplinary work hardening program. The only functional capacity evaluation submitted for review was the FCE performed for Dr. on 7/9/2007. This FCE failed to provide any data regarding the patient's functional status. Therefore, without additional documentation regarding this request, the medical necessity for the requested 10 sessions of work hardening was not established.

**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.  
Web-based version, Low Back – Work Hardening.
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).

**CompPartners, Inc. hereby certifies that the reviewing physician or provider has certified that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for the decision before the referral to CompPartners, Inc.**

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