

RYCO MedReview

Notice of Independent Review Decision

DATE OF REVIEW: 08/27/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Eight weeks of work hardening

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

Licensed by the Texas State Board of Chiropractic Examiners

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An MRI of the lumbar spine interpreted by M.D. dated 03/24/06

Evaluations with D.C. dated 05/10/06, 05/12/06, 06/09/06, 07/13/06, 08/23/06, 09/22/06, 10/20/06, 11/22/06, 01/22/07, 02/20/07, 03/23/07, 04/05/07, 05/21/07, 07/03/07, and 07/23/07

An evaluation with P.A.-C. dated 05/16/06

A Physical Performance Evaluation (PPE) with O.T.R. dated 05/16/06

An EMG/NCV study interpreted by D.O. dated 06/13/06

An evaluation with Dr. dated 06/30/06

A Required Medical Evaluation (RME) with M.D. dated 08/28/06

A letter from Dr. dated 12/20/06

A Functional Capacity Evaluation (FCE) with Mr. dated 03/28/07

An EMG/NCV study and lower extremity evoked potential study interpreted by M.D. dated 04/12/07

Request notes from Dr. dated 06/05/07 and 07/10/07

Letters of non-certification dated 06/08/07 and 07/16/07

PATIENT CLINICAL HISTORY [SUMMARY]:

An MRI of the lumbar spine interpreted by Dr. on 03/24/06 revealed degenerative changes at T11-T12 and L5-S1 and mild disc bulging at L3-L4. On 05/10/06, Dr. recommended manipulation, Biofreeze, a hot pack, a neuromuscular stimulator unit, an EMG/NCV study, and a pain management evaluation. Manipulation was performed with Dr. on 05/12/06. On 05/16/06, Mr. prescribed Soma and Ultram. A PPE with Mr. on 05/16/06 indicated the patient could not tolerate her work duties. An EMG/NCV study interpreted by Dr. on 06/13/06 revealed lower extremity sensory neuropathy. On 06/30/06, Dr. recommended Lidocaine and possible SI joint injections. On 07/13/06, Dr. noted the patient had been scheduled for a Benefits Review Conference (BRC). On 08/28/06, Dr. recommended a home exercise program, a non-steroidal anti-inflammatory, and modified work duty. On 11/22/06 and 01/22/07, Dr. recommended another EMG/NCV study. On 03/23/07, Dr. requested an FCE. Based on an FCE with Mr. on 03/28/07, a work re-entry program was requested. An EMG/NCV study interpreted by Dr. on 04/12/07 revealed an isolated L4 motor root involvement. A lower extremity evoked potential study interpreted by Dr. on 05/12/07 revealed an indication of involvement of the right L5 and left S1 sensory dermatome. On 05/21/07, Dr. requested a six week work hardening program. On 06/08/07 and 07/16/07, wrote letters of non-certification for the work hardening program.

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

Based upon the ODG physical therapy guidelines, recommendation would be for a four week work hardening program. Based upon the Guidelines, the patient should be able to receive adequate benefit within a four week completion timeframe for a work hardening program. If after that time the patient is still not ready for full duty release, she should be sent back to limited duty release and her job requirements gradually increased until she reaches the level of full duty,

as stated in the ODG physical therapy guidelines. Therefore, my finding is for recommendation of approval for four weeks of work hardening program.

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)