



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 12/03/07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of a work hardening program five times a week for two weeks

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.

Ten sessions of a work hardening program five times a week for two weeks – Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An evaluation with, D.C. dated xx/xx/xx
DWC-73 forms from Dr. dated xx/x/xx and 05/23/07
Fee Sheets from Dr. dated 09/28/06 and 06/06/07
A Functional Capacity Evaluation (FCE) with, M.S. and D.C. dated 10/05/06
Computerized Muscle Testing (CMT) and Physical Performance Evaluations (PPEs) with an unknown provider (no name or signature was available) dated 10/10/06, 10/31/06, 11/27/06, 04/25/07, 05/23/07, and 07/20/07
Letters of request from Dr. dated 10/12/06 and 06/27/07
Letters of denial, according to the ODG Guidelines, from, D.C. dated 10/26/06, and 06/30/07
An EMG/NCV study interpreted by, M.D. dated 10/30/06 and 10/31/06
An MRI of the cervical spine interpreted by, M.D. dated 11/01/06
MRIs of the lumbar spine and left shoulder interpreted by Dr. dated 11/06/06
A letter of approval, according to the ODG Guidelines, from Dr. dated 11/15/06
Explanations of Review and Health Insurance Claim Forms dated 04/25/07, 05/23/07, 06/06/07, 07/03/07, 07/06/07, 07/20/07, 08/15/07, 08/22/07, and 09/10/07
Letters of denial, according to the ODG Guidelines, from, D.C. dated 05/18/07 and 07/05/07
PPE with Ms. and Dr. dated 06/06/07
A preauthorization request from an unknown provider (no name or signature was available) dated 06/27/07
A prescription from Dr. dated 06/27/07
An evaluation with, M.D. dated 06/29/07
A phone conversation between the patient and Dr. dated 07/03/07
PPEs with Ms. and, D.C. dated 07/06/07 and 10/08/07
An evaluation with, M.D. dated 08/22/07
X-rays of the lumbar spine interpreted by, M.D. dated 09/10/07
An evaluation with, M.D. dated 09/10/07
A psychological evaluation with Ed., L.P.C. dated 09/18/07
An FCE with, D.C. dated 09/18/07
A preauthorization request from Dr. dated 09/25/07
Letters of non-certification, according to the ODG Guidelines, from, D.C. dated 10/01/07, 10/23/07, and 10/25/07
A letter of non-certification, according to the ODG Guidelines, from, D.O. dated 10/02/07
A letter of appeal, according to the ODG Guidelines, from Systems dated 10/19/07
A letter of approval for an injection and letter of denial for a CT myelogram, according to the ODG Guidelines, from, D.O. dated 10/31/07
The ODG Guidelines were not provided by the carrier or URA

PATIENT CLINICAL HISTORY

Based on FCEs with Ms. and Dr. on 10/05/06 and 06/06/07, the patient functioned at the sedentary light physical demand level. On 10/12/06, Dr.

recommended active physical therapy. On 10/26/06, Dr. wrote a letter of denial for the physical therapy. An EMG/NCV study interpreted by Dr. dated 10/30/06 revealed significantly prolonged left peroneal and tibial F-wave latency. An MRI of the cervical spine interpreted by Dr. on 11/01/06 revealed marginal osteophytes at C5-C6. MRIs of the lumbar spine and left shoulder interpreted by Dr. on 11/06/06 revealed a disc protrusion at L5-S1 and subdeltoid/subacromial bursitis in the shoulder. On 11/15/06, Dr. wrote a letter of approval for six physical therapy sessions. On 05/18/07, Dr. wrote a letter of denial for CMT testing. On 06/29/07, Dr. requested a functional restoration program. On 06/30/07, Dr. wrote a letter of denial for a pain management program. On 07/05/07, Dr. also wrote a letter of denial for a pain management program. On 08/22/07, Dr. recommended injections and a CT myelogram of the lumbar spine. On 09/10/07, Dr. prescribed Mobic. On 09/18/07, Ms. recommended a work hardening program. On 09/25/07, Dr. wrote a letter of precertification request for a two week work hardening program. On 10/01/07, 10/23/07, and 10/25/07, Dr. wrote letters of non-certification for a work hardening program. On 10/02/07, Dr. wrote letters of denial for a CT myelogram and an injection. On 10/19/07, wrote a letter of appeal. On 10/31/07, Dr. wrote a letter of denial for a CT myelogram of the lumbar spine and a letter of approval for a lumbar injection.

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

Based upon the ODG Guidelines, the patient does meet the criteria for admission to the work hardening program. It physically appears that he can meet the needs for progressive reactivation and participation for a minimal of four hours a day, three to five days a week. There is no documentation indicating the patient does not have a job to return back to with the employer that he was previously employed with Aramark. Therefore, he meets that qualification unless other documentation is provided indicating that the employee's job position is no longer available. The patient must also be able to benefit from the program. He has undergone screening programs, psychological evaluation demonstrating that he is a candidate for such a program. Based upon the provided documentation, he still does suffer from ongoing pain and physical dysfunction that would not allow him to meet his current physical demand level required by his employer. Therefore, he meets that guideline. The worker must also be no more than two years post date of injury and the patient falls within that guideline, as well. The program must be less than four weeks and the request is for five times per week for two weeks, which does also meet that guideline for admission to the work hardening program. Therefore, my finding is for approval of the 10 sessions of the work hardening program five times a week for two weeks.

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 AND KNOWLEDGE BASE
- 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)