



Notice of Independent Review Decision

**DATE OF REVIEW:** 12/05/07

**AMENDED DATE:** 12/11/07

**IRO CASE #:**

**NAME:**

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

Determine the medical necessity for work conditioning for the lumbar spine.

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

Texas Licensed Family Medicine Specialist.

**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 work conditioning for the lumbar spine.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- **Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 11/26/07.**
- **Company Request for Independent Review Organization dated 11/26/07.**
- **Fax Cover Sheet/Authorization Request dated 11/27/07, 11/26/07.**
- **Request for a Review by an Independent Review Organization Form dated 11/16/07.**
- **Pre-Authorization Determination dated 10/24/07, 10/3/07.**
- **Rationale Report dated 10/23/07, 10/2/07.**
- **Notice to, Inc. of Case Assignment dated 11/27/07.**
- **Physical Therapy Prescription dated 9/18/07.**
- **Physical Therapy Evaluation/Plan of Care dated 9/27/07.**

- **Functional Capacity Evaluation Report dated 8/28/07.**
- **Re-Evaluation Progress Report dated 8/8/07.**
- **Plan of Care Report dated 8/9/07.**

Guidelines were not supplied by the URA for this referral.

**PATIENT CLINICAL HISTORY [SUMMARY]:**

**Age:** xx

**Gender:** Male

**Date of Injury:** xx/xx/xx

**Mechanism of Injury:** xxxxx and "xxxxxx"

**Diagnosis:** Lumbago.

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

The patient is a xx-year-old male who was injured on xx/xx/xx. He was ". His diagnosis was lumbago. A request for work conditioning was non-certified by two other reviewers. This reviewer concurs that work conditioning is not medically necessary based on the information provided. The mechanism of injury indicated that the patient and according to the records, he has not worked since May 2007. He received extensive previous therapy including six weeks of physical therapy which was reported to result with minimum improvement and then he received an additional 10 visits of physical therapy, which caused moderate improvement. He also was treated with chiropractic therapy, stretches, and had a functional capacity examination. A physical therapy note from August 8, 2007 reported that he did have good rehabilitation potential. The functional capacity examination performed on August 28, 2007 documented that the patient was able to do moderate physical work, however, his job requirements were for heavy physical labor. His functional aerobic capacity was adequate for medium physical demands. There were no medical notes provided by Dr.. The previous two reviewers made several attempts to reach his office and did not receive a return call. According to the American Physical Therapy Association Guidelines for work conditioning, in order to qualify, the patient must have a job goal, a stated or demonstrated willingness to participate, and have identified systemic neuromusculoskeletal physical and functional deficits that interfere with work. It should begin no more than one year following the date of injury and there needs to be a comprehensive multidisciplinary evaluation. There was functional capacity examination performed by the physical therapist but no multidisciplinary examination was provided. As mentioned, there were no physician progress note substantiating the need for this program. It is not clear to this reviewer why, after this mechanism of injury, the patient still was off work and unable to progress in an independent exercise program to restore his physical ability from moderate to heavy work capacity. He was provided with extensive therapy previously with six weeks of therapy then an additional 10 visits. Based on the information provided, this reviewer believes that work conditioning is not necessary and systemic neuromusculoskeletal deficits were not adequately documented

other than the fact that he can do medium physical labor at this point. It would be reasonable to expect that the patient should be capable of increasing his aerobic capacity through an independent home exercise program, given his extensive past treatment with therapy. Based on the foregoing, the request for work conditioning is non-certified.

**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 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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