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Notice of Independent Review Decision

DATE OF REVIEW: 12-14-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening Program 5 X 4

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

Certified by The American Board of Physical Medicine and Rehabilitation

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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/Overturn
		Prospective	847.2	97545	20	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of Adverse Determinations Report Dates 11-05-07 and 11-14-07
DWC Form-1 dated 06-21-07

DWC Form PLN-11 dated 08-14-07
DWC Form PLN-9 dated 07-12-07
Worker's Compensation Request for Medical Care 06-20-07
Physician Activity Status Reports 06-21-07, 06-25-07, 06-27-07, 06-28-07,
07-02-07
SOAP notes 08-01-07, 08-02-07, 08-14-07, 08-20-07, 08-24-07, 07-30-07,
09-05-07
Physician Evaluation dated 07-18-07
Required Medical Examination dated 08-07-07
Cervical Spine X-rays 08-16-07
Follow-up notes 08-22-07, 09-26-07, 11-12-07
Functional Capacity Evaluation (FCE) 10-24-07
Pre-auth Request for the Work Hardening Program 10-29-07 and 11-06-07
Medical Conference with Physician 11-14-07
Request for the Work Hardening Program to be presented for Medical Dispute
Resolution 11-19-07
Source Criteria: Clinical Evidence ODG
Citation: ODG-TWC Back chapter

PATIENT CLINICAL HISTORY:

According to the records received, the claimant's injury date was xx/xx/xx and the initial diagnoses included lumbar/cervical strain/pain, cervicalgia, right shoulder strain/pain, hip strain, cervical/lumbar fusion osteoarthritis, bilateral hips.

The evaluation of 07-18-07 noted tenderness to palpation with a decreased range of motion. The impressions included a cervical sprain, lumbar sprain, and right trapezius pain. The claimant is status post C5-6, C6-7 ACDF in 1998. Physical therapy was started, and diagnostic studies (e.g., CT scan of the cervical spine) were ordered.

The physician note of 08-22-07 noted that claimant was improving with therapy and job restrictions. The claimant reportedly wanted to return to work, precipitating a functional capacity evaluation being completed. This led to a request for a work-conditioning program. The request was not certified, and reconsideration was filed.

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

According to the Reviewer, as noted in the Official Disability Guidelines (ODG), there is some data supporting the use of such a program in a chronic back pain situation. Based on the date of injury and the initial request, this would not be considered as a chronic pain situation. Also, as specifically stated in the ODG, such a program is not indicated for an acute injury, which again according to the Reviewer, given the date of injury, this would be considered as an acute injury. Lastly, there are no clinical data that such an interdisciplinary program which includes psychiatric intervention is needed. There are no objective findings of a psychiatric malady related to this patient's condition. Therefore, based on the clinical data presented and specific notation of the ODG, in the opinion of the Reviewer, there is no medical necessity for a work hardening program presented in this case.

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)**