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Notice of Independent Review Decision

DATE OF REVIEW: 10-31-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening 20 sessions

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

Certified by The National 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)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS, CPT, NDC Codes	Service Units	Upheld/ Overturn
		Prospective	729.2	97545 97546	1	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Notice dated 08-24-07 & 09-18-07
Physician Advisor's Review Reports dated 08-24-07 & 09-18-07
Letter for Medical Necessity dated 09-13-07 & 10-16-07
Work Hardening Assessment Psychosocial History dated 08-20-07

Physical Performance Evaluation dated 08-10-07
Functional Abilities Evaluation dated 08-10-07
ODG Guidelines – Criteria for admission to a Work Hardening Program

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant sustained a closed head injury while at work.
He complained of immediate pain in the neck and head. He received conservative treatment including physical therapy and medications. A cervical MRI showed multilevel annular bulge with canal stenosis. Electrodiagnostics showed bilateral carpal tunnel syndrome and radiculitis at C5 and C6. His psychosocial evaluation showed moderate depression with mild anxiety. He continues to have neck pain and heaviness in the right upper extremity as well as headaches. The treating provider's request for work hardening was non-certified.

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

The Reviewer determined that the records provided do not support the requested work hardening program for 20 sessions. From the records, the claimant appears to have received a course of physical therapy for 12 sessions and was reported to have improved. There were no initial findings with subsequent clinical findings provided to support the report of improvement from the 12 sessions of physical therapy.

The physical performance evaluation (PPE) does not support maximal effort from the claimant, which calls into question the benefit from the intensive work hardening program. The PPE reported that the claimant had little pain in the right shoulder while he reported significant pain in the right lower extremity that was unrelated to the injury. This would more than likely limit the claimant's participation in the program. The claimant displayed a positive rapid exchange grip (REG) indicating submaximal effort. The arm lift was recorded at an average of 56 pounds while the high near lift was 35 pounds. This also demonstrates submaximal effort from the claimant. Objective work-limiting functional deficits were not credibly identified with the PPE due to questionable effort from the claimant. All of these factors call into question the ability of the claimant to benefit from the program. There was no defined return to work goal agreed to by the employer and employee as per ODG guidelines' criteria for work hardening.

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)**