

IRO NOTICE OF DECISION – WC

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Notice of Independent Review Decision

DATE OF REVIEW: 08-31-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening Program x 30 sessions

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

Diplomate, American Chiropractic Academy of Neurology
Diplomate, American Academy of Pain Management
Eligible, American Board of Chiropractic Orthopedics
Certified, Traffic Accident Reconstructionist
Certified, Manipulation Under Anesthesia
Qualified Medical Evaluator

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	729.1 V45.8 847.2 722.10 722.83	97545 97546	30	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Pre-Authorization Determination report date 11-30-06
Pre-Authorization Request (reconsideration) dated 12-15-06
Pre-Authorization Determination (denial) dated 12-22-06
XR SP Lumbar Spine dated 08-22-06
MRI of the Lumbar Spine dated 06-12-06
Practitioner Request Letter dated 10-19-06
Supplemental Report dated 09-06-06
Medical Dispute Resolution For Work Hardening dated 01-31-07
Independent Medical Evaluation (IME) dated 08-16-06
Reconsideration For Work Hardening (Medical Necessity) dated 12-13-06
Review of Medical History & Physical Exam dated 10-12-06

PATIENT CLINICAL HISTORY:

This claimant was injured when he inadvertently fell backwards injuring his back. Initial DX – contusion of the spine. MRI on 11-5-04 showed a severe bulge at L4-L5 with some neuroforaminal narrowing. Also narrowing at L3-4 (not as severe). Electrodiagnosing testing done on 12-19-04, left L5 radiculopathy was reported, also had an injection of the sacroiliac area. He had decompression at L4-5 and instrumental fusion on 9-30-05. He continues to complain of low back pain. The treating practitioner requests 30 sessions of work hardening program. The request for work hardening was non-certified. The Physician Advisor noted “ the claimant is highly unlikely to return to work.”

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

In reviewing the IME from about 1 year ago, the physician stated on page 4: “In my opinion, the claimant has reached maximally medically (MMI) . . . In terms of work, please note he is medically retired.” His being declared MMI means, by definition, that the claimant was also Permanent & Stationary (P&S) by 8-15-06. In other words, the claimant’s previously being maximally medically improved, with the treating practitioner providing no reported aggravations or flare-ups or exacerbations of his prior P&S status, seems to clearly belie the medical reasonableness of any work hardening. It is also unclear why the treating practitioner would reasonably opine that the claimant required a work hardening program or that he would likely return to work more than one year after having retired.

In his 9-6-06 supplemental report, the physician noted that he had rated the claimant with permanent recommendation for restricted work as well as permanent work preclusion against lifting more than 25 pounds. Given the physician's prior determination of MMI/P&S, his noting that the claimant had retired, and given his permanent work preclusions, I disagree with the treating practitioner's stated beliefs on 1-31-07 that the claimant could medically improve from a work hardening program, that he would likely come out of retirement at all, let alone to resume working at a higher level of functioning than for which the report of 9-6-06 had already permanently precluded. There is also no documentation in the file that the claimant failed, let alone attempted, a self-directed home exercise program, which is supported by ACOEM Guidelines and InterQual criteria. I would therefore recommend upholding the prior non-certifications, and specifically recommend denial of the requested 30 sessions of work conditioning at 6 hours per day, 5 days per week, for 6 weeks as not reasonable or necessary on an industrial basis, especially having previously been declared MMI on the report of 8-15-06.

Overall, evidence-based guidelines such as the ACOEM Guidelines (pp. 299-301,315), the Official Disability Guidelines 10th edition (pp. 1111,1122, 1153, 1421, et seq.), and the ODG- TWC 2005 edition (pp. 624-626, 649), all generally state and reference that if any individual's restoration is insignificant in relation to the extent and duration of the physical medicine services required to achieve such potential and restoration, then the services are not considered reasonable or necessary. Evidence of objective functional improvement is essential to establishing reasonableness and necessity of care and progression toward a self directed care program and maximizing activity tolerance (ACOEM pg. 92, Mercy 121) are best practices and reduce somatization and physician dependence (ACOEM pg. 49, Mercy 118-122, InterQual 220 MDR).

Lumetra's Physician Reviewer has no known conflicts of interest in this case, pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code § 413.032, and § 12.203 of this title.

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

X INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

X 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)