C-IRO, Inc.

An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

Notice of Independent Review Decision

DATE OF REVIEW: FEBRUARY 26, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity (RETROSPECTIVE) work hardening/work conditioning -- 10/2/07, 10/3/07, 10/4/07, 10/5/07, 10/8/07, 10/9/07, 10/11/07, 10/12/07

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

MD, Board Certified Orthopedic Surgeon

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.

The reviewer finds that medical necessity existed for work hardening/work conditioning -- 10/2/07, 10/3/07, 10/4/07, 10/5/07, 10/8/07, 10/9/07, 10/11/07, and 10/12/07

Injury Date	Claim number	Type	Begin Date	End Date	ICD-9/ DSMV	HCPCS/NDC	Service Units	Amount Billed	Upheld/ Overturned
		Retro	10/2/07	10/5/07	724.2	97545	4	$512	Overturned
		Retro	10/2/07	10/5/07	724.2	97546	4	$512	Overturned
		Retro	10/8/07	10/12/07	724.2	97545	4	$512	Overturned
		Retro	10/8/07	10/12/07	724.2	97546	4	$896	Overturned

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Notice of disputed issue letter, 06/25/07
Official Disability Guidelines Treatment in Worker's Comp 2007 Updates, Low Back . Work conditioning, work hardening
WC first report of injury,
Dr. office notes 06/07/07, 06/21/07, 07/24/07,12/19/07
Dr. office notes 08/01/07, 08/06/07, 8/29/07
MD, 12/21/07
MRI lumbar 03/13/07
Behavior health screening assessment 08/01/07
Physical therapy records 09/10/07 to 09/28/07
Functional capacity evaluation 10/02/07
Pain management /work hardening sessions, 10/02/07 to 10/12/07
Work hardening weekly progress reports
Letter from claimant 04/02/07
UR pre authorization decision 01/07/07
Explanation of medical benefits

PATIENT CLINICAL HISTORY [SUMMARY]:

This male teacher sustained a low back injury after he lost his balance and fell down approximately two to three stairs. The records indicated that the claimant reported low back pain with bilateral leg pain. An MRI of the lumbar spine showed multilevel disc degeneration and facet arthrosis. The claimant treated conservatively however, the back pain persisted. A Functional Capacity Evaluation performed on 10/02/07 noted the claimant functioning in the light work capacity with significant limitations. Participation in a comprehensive multidisciplinary rehabilitation program was recommended. The claimant attended eight work hardening sessions from 10/02/07 through 10/12/07. The weekly progress report noted that the claimant remained limited in functional abilities.

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

The work hardening program appears to have met the medical necessity criteria per ODG guidelines. The patient was noted by functional capacity evaluation to be only capable of light duty work and he had a medium duty job position. His job, therefore, appeared to have exceeded his capabilities at that time according to the functional capacity evaluation. The claimant was within two years of the date of his injury. The work hardening was completed within four weeks and included eight sessions. This is within the ten visits over eight weeks per ODG guidelines. The requested work hardening and work conditioning program does appear to meet the appropriate criteria for medical necessity.

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)**