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Notice of Independent Review Decision

Revised Notice-Code Deleted (page 4)

DATE OF REVIEW: 01-09-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Outpatient Work Hardening Program

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 & Rehabilitation

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC Codes	Service Units	Upheld/ Overturn
		Retrospective	719.45	97545 97546	14 84	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Physician Bill Review Findings- Date of Notice: 11-02-07 & 12-10-07
Explanation of Payment – Dates of Service: 10-01-07 to10-04-07; 10-08-07 to10-12-07; 10-15-07 to 10-19-07; 10-22-07 to 10-25-07; 10-25-07 to10-25-07
Notice of Utilization Review Findings – Date of Notice: 08-23-07; 09-11-07; 09-26-07 & 10-04-07

MDR Checklist 01-4-08
Form DWC060 – Table of Disputed Services Only
Physician Referral dated 07-25-07
Letter of Medical Necessity – Request date 07-25-07
Health Insurance Claim Forms 10-10-07; 10-17-07; 10-24-07; 10-31-07;
Weekly Progress Report: 10-01-07 to 10-05-07; 10-08-07 to 10-12-07; 10-15-07 to 10-19-07; 10-22-07 to 10-26-07;
Request for Reconsideration 11-30-07
Letter dated 01-03-08
Functional Capacity Evaluation 08-07-07 & 10-25-07
Behavioral Health Screening Assessment 08-01-07
Biofeedback Training 10-01-07; 10-08-07 & 10-15-07
Self-Hypnosis Training 10-02-07; 10-04-07; 10-09-07; 10-11-07; 10-16-07; 10-18-07
Process Group Notes: Week of 10-01-07; 10-08-07; 10-15-07; 10-22-07
Date of Consultation: 08-01-07
MRI Lumbar Spine 07-09-07
Physician S.O.A.P notes 06-05-07; 06-07-07; 07-02-07; 07-03-07
Official Disability Guidelines (ODG): Criteria for admission to a Work Hardening of Work Conditioning Program

PATIENT CLINICAL HISTORY:

The claimant sustained an injury on after falling 8-10' to the ground and landing on his left hip. The claimant underwent left hip surgery, and post surgical treatment included active and passive physical therapy, medications, epidural steroid injections, and chiropractic treatment. The claimant completed 20 sessions of a chronic pain program and several sessions of a work hardening program.

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

Based on the medical records and per Official Disability Guidelines (ODG), there is no clinical indication presented for this program. Several points are noted:

a) Work hardening is limited to those who require a multi-disciplinary protocol. The chronic pain program notes indicate a return to pre-injury functionality in terms of weight strength ability.
b) There is no notation of a specific job to return to, that this was specifically designed for the job held by the claimant. It is noted that it was the goal of the claimant to return to work at the same position, there was no documentation that there was such a position available to the claimant.
c) A work hardening program is to be job specific and goal oriented to the job that is to be returned to. The program outlined for this claimant does not address the specific needs of the job description noted and did not include a psychiatric condition that would require a multi-disciplinary approach.

d) The notes presented do not identify the outcome measurements that would be required prior to entry into this specific program or how the selection process was made.

<u>A Description and the Source of the Screening Criteria or Other Clinical Basis Used to Make the Decision:</u>

- ☐ **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**
- 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)**