

Notice of Independent Review Decision

DATE OF REVIEW: 6/19/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

10 visits to a Work Hardening program (5x2)

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/ NDC	Upheld/ Overturned
		Prospective	847.2	97545 97546	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Request for Review by an Independent Review Organization
Adverse determination letter dated 5/13/08
Adverse determination letter dated 5/29/08
Medical records dated 12/12/07, 1/7/08
Functional Capacity Evaluation dated 2/11/08
Functional Capacity Evaluation dated 4/15/08
Chronic Pain Evaluation dated 4/29/08
Pre Auth Request for Work Hardening (Reconsideration) dated 5/21/08

Initial Report/Impairment Rating dated 3/26/08
Physician letter dated 5/6/08
Official Disability Guidelines cited but not provided

PATIENT CLINICAL HISTORY

According to the information provided, this xx-year-old claimant has a date of injury of xx/xx/xx. The patient has diagnosis of low back pain and has undergone two spinal surgeries. He had lumbar decompression surgery in 10/06 with fusion at the L5-S1 level, and subsequent hardware removal six months later due to "painful hardware syndrome." The patient has had physical therapy and has ongoing complaints of pain.

A Functional Capacity Evaluation (FCE) obtained 2/08 noted "poor endurance during testing," and a repeat FCE done two months later demonstrated decreased functionality. A chronic pain evaluation obtained in 4/08 noted the patient had completed a chronic pain management program, and demonstrated the chronic pain as was already noted to have been established. The request for 10 sessions of a work hardening program was non-certified.

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

In the opinion of the Reviewer, based on the documentation provided for review and the Official Disability Guidelines, there is no indication that a work hardening program for this patient is medically necessary. The Reviewer commented that while the Division mandated Official Disability Guidelines recommend work hardening as an option, there are several distinct criteria that are to be met.

The Reviewer noted that a work hardening program should be work simulation, and in this case there is nothing to indicate that this standard has been met. The information provided for review does not include any work agreement between the employer and employee, any letter from the employer or documentation of a job to return to, or any specific job simulation as required. Additionally, there is no indication for a work hardening program when the date of injury is greater than two years ago. (Criteria #4 ODG)

The Reviewer commented that, according to Official Disability Guidelines, these two points alone negate the use of a work hardening program for this patient, and this case fails to meet the requirements noted in the Official Disability Guidelines.

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)