

Notice of Independent Review Decision

DATE OF REVIEW: 03-22-08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening

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/ NDC	Service Unit	Upheld/ Overturned
		Prospective		97799	20	Upheld

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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Denial Notices, dated 12-27-07 and 01-29-08
Patient Profile
Appeal and Request for Work Hardening
IRO Position Statement
Physician prescription for work hardening, dated 12-14-07 and 03-08-08
Consultation report, dated 12-14-07
Evaluation Summary Report, dated 12-14-07
Behavioral Assessment of Pain Clinical Report, dated 12-14-07
Official Disability Guidelines (ODG) Treatment Low Back – Lumbar & Thoracic
(Acute & Chronic)

PATIENT CLINICAL HISTORY:

The claimant's injury to the low back occurred. The claimant was diagnosed with sacroiliitis. The claimant completed physical therapy, and a Functional Capacity Evaluation (FCE) was performed. Apparently the results of the FCE showed significant deficits in her current capacity compared to her job requirements. The treating provider prescribed work hardening program to assist the claimant.

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

According to the Reviewer, there was no objective evidence in the records provided of any significant improvement with intermediate levels of chiropractic care/physical therapy that would support that the claimant would benefit from the requested work hardening program as per ODG. There was no defined return to work goal agreed to by the employer as per ODG. Therefore, the Reviewer determined that the medical necessity of the requested work hardening program is not established.

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**

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- 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)**