

## Notice of Independent Review Decision

DATE OF REVIEW: 01/22/09

IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work conditioning program

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

The TMF physician reviewer is board certified in physical medicine/rehabilitation with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

### 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.

It is determined that the work conditioning program is not medically necessary to treat this patient's condition.

### INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Information for requesting a review by an IRO – 01/07/09
- Adverse determination letter from – 11/06/08, 12/06/08
- Pre-Authorization Request Form – No date
- Prescription for work conditioning 5 X 3 weeks – 10/28/08
- Medical Report by Dr. – 10/27/08

- Progress note by Dr. – 11/03/08
- Request for preauthorization by – 12/02/08
- Prescription for work conditioning 3 X 2 weeks – 11/24/08
- Request for reconsideration by Dr. – 11/24/08
- Report of MRI of the lumbar spine – 08/15/08
- Initial Mental Health Status Evaluation by – 11/07/08
- Physical Therapy progress notes – 10/27/08
- Evaluation Summary Report – 09/11/08

**PATIENT CLINICAL HISTORY [SUMMARY]:**

This patient sustained a work related injury on xx/xx/x when she was slammed to the ground during a training session. This resulted in pain to the lower back. She has been treated with physical therapy as well as participation in a work conditioning program.

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

This patient received 4 weeks of work conditioning with minimal improvement. Further significant improvement is not expected with an extension of the same work conditioning program. Therefore, it is determined that 4 more weeks of working condition program are not medically necessary.

**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)