



## Notice of Independent Review Decision

**DATE OF REVIEW:** 11/06/09

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Twenty Sessions of Work Hardening

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

Board Certified in Physical Medicine & 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)

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.

TWENTY SESSIONS OF WORK HARDENING - **UPHELD**

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- Required Medical Evaluation (RME), M.D., 07/29/09

- Subsequent Evaluation, D.C., 08/06/09
- Work Hardening Assessment/Psychosocial History, M.A., LPC, 08/07/09
- Physical Performance Evaluation (PPE), Dr. 08/20/09
- Pre-Authorization Request, Spine & Rehab, 08/29/09
- Denial Letter 09/03/09, 09/25/09
- Reconsideration for Work Hardening, Dr. 09/18/09
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient slipped and twisted at work subsequently injuring his lower back. In the past, the patient has been treated with physical therapy, as well as an MRI of the lumbar spine. The claimant also underwent chiropractic treatment and an EMG. Medications included Flexeril, Cataflam, Robaxin, Ultram, and Medrol Dosepak.

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

No, I do not feel the 20 sessions of a recommended work hardening program are medically reasonable or necessary.

My decision is based upon two separate and distinct medical facts. Firstly, the patient does not meet ODG criteria for work hardening, as there is no job for him to return to. This has been clearly documented in the medical record and is a requirement of the ODG for a work hardening program. Secondly, and more specifically, there have been a number of recommendations regarding treatment for this claimant, including at least two requests for epidural steroid injections by treating physicians, as well as a recommendation that this be performed by the Designated Doctor. The claimant has a documented radiculopathy and documented disc herniation compatible with symptomatology, physical examination findings, and diagnostic testing. As such, he has not exhausted routine conservative treatment that would be anticipated prior to enrollment in a work hardening program.

**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)**