



Notice of Independent Review Decision

DATE OF REVIEW: 12/30/09

IRO CASE #:

NAME:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Determine the appropriateness of the previously denied request for work hardening x 10 days.

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

Texas licensed chiropractor.

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.

The previously denied request for work hardening x 10 days.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Notice of Utilization Review Findings dated 12/23/09.
- Electrodiagnostic Evaluation / EMG-NCV dated 7/27/09.
- Radiographic Biomechanical Report dated 11/10/09.
- Lumbar Spine MRI without Contrast dated 8/25/09.

- Referral Report dated 9/14/09.
- Follow Up WC Visit Note dated 9/29/09.
- Examination Form dated 9/29/09.
- Physical Medicine & Rehabilitation Treatment Plan dated 9/29/09.
- Initial Psychological Evaluation & A Trial of 10 Sessions of Work Hardening dated 10/26/09.
- Industrial Rehabilitation Comprehensive Care Plan (date unspecified).
- Functional Capacity Evaluation dated 10/28/09.
- Low Back Pain Disability Questionnaire dated 10/28/09.
- Notification Letter dated 11/21/09.

There were no guidelines provided by the URA for this referral.

PATIENT CLINICAL HISTORY (SUMMARY):

Age: xx

Gender: Male

Date of Injury: xx/xx/xx

Mechanism of Injury: Slipped

Diagnosis: Sprain/strain of lumbar region.

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

This male was involved in a work related injury on xx/xx/xx. The mechanism of injury was he slipped and twisted his lower back. The diagnosis was sprain/strain of the lumbar region. The claimant underwent a course of physical therapy (PT). On 10/28/09, the claimant underwent a Functional Capacity Evaluation (FCE). This revealed that he was functioning at a light/medium physical demand level. His job required a physical demand level (PDL) which was heavy. The claimant underwent a psych evaluation, on 10/26/09, where it was determined that he was a candidate for a work hardening program. A request for 10 sessions of work hardening was submitted. The purpose of this review is to determine the medical necessity for the requested 10 sessions of work hardening. The medical necessity for the requested 10 sessions or work hardening was established. The claimant had completed lower levels of PT and was evaluated for a return to work. However, an FCE determined that the claimant was not able to function at his job required PDL of heavy. The ODG support an initial trial of 10 sessions of work hardening and indicate that an initial trial of "10 visits over 2 weeks" can be considered appropriate. The claimant had completed lower levels of care and is a candidate for work hardening. He also has a job to return to. Therefore, the request for 10 sessions of work hardening can be considered appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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.

Official Disability Guidelines (ODG), Treatment Index, 7th Edition (web), 2009, Low back – Work Hardening.

- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).