Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

Notice of Independent Review Decision

DATE OF REVIEW: 03/10/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten sessions of work hardening

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

Board Certified in Orthopedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

X 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.

Ten sessions of work hardening - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

An Employer's First Report of Injury or Illness form dated xx/xx/xx

An evaluation with R.N. dated 09/16/08
A physician report from an unknown provider (signature was illegible) dated 09/16/08
X-rays of the lumbar spine interpreted by Dr. (no credentials were listed) dated 09/16/08
Evaluations with M.D. dated 09/17/08, 10/01/08, 11/03/08, 12/08/08, 01/12/09, 02/09/09, 03/13/09, 04/13/09, 05/20/09, 06/26/09, 08/05/09, 09/11/09, 10/19/09, 12/04/09, 01/11/10, 02/01/10, and 02/26/10
DWC-73 forms from Dr. dated 09/17/08, 10/01/08, 11/03/08, 12/08/08, 01/12/09, 02/09/09, 03/13/09, 04/13/09, 05/20/09, 06/26/09, 08/05/09, 09/11/09, 10/19/09, 12/04/09, and 01/11/10
Chiropractic therapy with D.C. dated 09/18/08, 10/03/08, 10/08/08, 10/15/08, 10/21/08, 11/03/08, 11/24/08, and 12/04/08
Chiropractic therapy with D.C. dated 09/23/08 and 11/21/08
A retrospective review from M.D. dated 12/04/08
An MRI of the lumbar spine interpreted by M.D. dated 12/19/08
A peer review from M.D. dated 01/19/09
An EMG/NCV study interpreted by, M.D. dated 02/16/09
An evaluation with M.D. dated 06/02/09
A note from Dr. dated 06/19/09
Mental health evaluations with L.P.C. dated 07/14/09 and 12/22/09
A DWC-11 form from the insurance carrier dated 07/22/09
Functional Capacity Evaluations (FCEs) with an unknown provider (no name or signature was available) dated 08/13/09, 11/11/09, 12/17/09, and 02/01/10
Prescriptions from Dr. dated 08/21/09 and 08/31/09
A Notice of IRO Decision from dated 09/26/09
A Designated Doctor Evaluation with M.D. dated 10/12/09
A preauthorization request for a work hardening program from Dr. dated 12/28/09
A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O.
A request for reconsideration letter from Dr. dated 01/13/10
A letter of adverse determination, according to the ODG, from, M.D. dated 01/20/10
An IRO Summary from TLC Claims Management dated 02/23/10
The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

The Employer's First Report of Injury or Illness stated the patient was a male who strained his back during normal body movement at work. On 09/16/08, an unknown physician prescribed Motrin and Flexeril. X-rays of the lumbar spine interpreted by Dr. on 09/16/08 showed minimal degenerative changes. Chiropractic therapy was performed with Dr. from 09/18/08 through 12/04/08 for a total of eight sessions. Chiropractic therapy was also performed with Dr. on 09/23/08 and 11/21/08. An MRI of the lumbar spine interpreted by Dr. on 12/19/08 showed a disc protrusion and bulge at L2-L3, moderate to severe encroachment of the neural foramina at L3 through S1, and a broad based right dorsolateral L4-L5 disc protrusion. An EMG/NCV study interpreted by Dr. on

02/16/09 showed acute right S1 radiculopathy. Based on a mental health evaluation with Ms. on 07/14/09, 10 sessions of a pain management program were requested. On 07/22/09, the insurance carrier accepted a compensable injury in the form of a lumbar sprain/strain only. An FCE on 08/13/09 indicated the patient functioned at the light physical demand level. On 08/21/09, Dr. prescribed a conductive garment and electrolyte solution. On 08/31/09, Dr. prescribed an electrical muscle stimulator and supplies. On 10/12/09, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 0% whole person impairment rating. On 12/04/09, Dr. felt the patient was not yet at MMI. On 12/22/09, Ms. recommended a work hardening program. On 12/28/09, Dr. provided a preauthorization request for 10 sessions of a work hardening program. On 12/30/09, Dr. wrote a letter of non-certification for the work hardening program. On 01/13/10, Dr. wrote a request for reconsideration for the work hardening program. On 01/20/10, Dr. wrote a letter of non-certification for the work hardening program. An FCE on 02/01/10 indicated the patient functioned at the medium physical demand level. On 02/26/10, Dr. again requested a work hardening program.

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

The patient has experienced a sprain/strain and there has never been a reason the patient could not work with mild restrictions for several weeks and then no restrictions after three months. It appears that modified duty is provided by his employer. The patient's neurological examination has been normal. There has been no objective reason for his treating physicians to maintain him in an off work environment. The patient has undergone an FCE. These, however, only measure a patient's desire and tolerance, they do not necessarily measure the patient's capacity. It appears there has not been significant improvement in the claimant's clinical condition based on the records provided. Therefore, the recommended 10 sessions of a work hardening program would not be reasonable or necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE**
- ☐ **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
- [x] 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
- [ ] 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)