



---

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:** 10/29/10

**IRO CASE #:**

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

80 hours of work conditioning

**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:

- 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.

80 hours of work conditioning - Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

## Notice of Employee's Work-Related

Injury/Illness form dated xx/xx/xx

X-rays of the thoracic and lumbar spines interpreted by M.D. dated 12/31/08

Evaluations with M.D. dated 12/31/08 and 01/19/09

A daily patient management note from dated 01/30/09

Evaluations with M.D. dated 02/17/09, 02/27/09, 03/01/09, 03/13/09, 03/27/09, 04/17/09, 05/01/09, 09/11/09, 09/25/09, 10/23/09, and 11/20/09

Evaluations with M.D. dated 02/18/09, 03/03/09, 03/11/09, 04/29/09, and 06/04/09

PLN-11 forms dated 02/18/09 and 09/02/09

MRIs of the knees interpreted by M.D. dated 02/26/09

A daily pain management note from dated 02/27/09

Evaluations with M.D. dated 06/05/09, 06/19/09, 07/29/09, 09/18/09, 12/11/09, 01/18/10, 02/26/10, 04/05/10, 05/21/10, 07/14/10, and 08/20/10

Designated Doctor Evaluations with D.O. dated 07/21/09 and 11/24/09

A letter of medical necessity from M.D. dated 07/28/09

A letter of authorization from Forte dated 08/05/09

Lumbar epidural steroid injections (ESIs) at L5-S1 with Dr. dated 08/06/09 and 10/02/09

Evaluations with Dr. dated 08/11/09 and 10/06/09

An operative report from Dr. dated 08/28/09

Evaluations with M.D. dated 02/09/10, 04/13/10, 05/21/10, and 07/06/10

Chiropractic therapy was performed with D.C. dated 02/26/10

Functional Capacity Evaluations (FCEs) with (no credentials were listed) dated 03/03/10, 09/02/10, and 09/15/10

An MRI of the lumbar spine interpreted by M.D. dated 04/07/10

An EMG/NCV study interpreted by M.D. dated 06/08/10

A Required Medical Evaluation (RME) with M.D. dated 07/07/10

A preauthorization request for work conditioning from D.C. dated 09/03/10

Work conditioning daily notes from Dr. dated 09/10/10, 09/13/10, 09/14/10, 09/15/10, and 09/16/10

A concurrent review request from Dr. dated 09/15/10

A preauthorization request from Dr. dated 09/16/10

A letter of non-authorization, according to the Official Disability Guidelines (ODG), from M.D. dated 09/22/10

A request for reconsideration from Dr. dated 09/29/10

A letter of non-authorization, according to the ODG, from D.O. dated 10/07/10

The ODG Guidelines were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

X-rays of the thoracic spine and lumbar spine interpreted by Dr. on 12/31/08 showed only mild scoliosis to the right. On 01/19/09, Dr. recommended Norco, continued physical therapy, an MRI, and pain medications. Physical therapy was performed with Ms. on 01/30/09 and with Ms. on 02/27/09. An MRI of the left knee interpreted by Dr. on 02/26/09 showed mild edema in the infrapatellar fat pad medially. An MRI of the right knee interpreted by Dr. on 02/26/09 showed a partial thickness undersurface tear of the posterior horn of the medial meniscus

and focal chondromalacia of the medial patellar facet and joint fluid present. On 06/05/09, Dr. prescribed Motrin and recommended MRIs of the cervical and thoracic spine, lumbosacral spine, left wrist, an orthopedic evaluation for the knees, and a pain management consultation. Lumbar ESIs were performed by Dr. on 08/06/09 and 10/02/09. On 08/28/09, Dr. performed a right knee arthroscopy, chondroplasty, partial synovectomy, and debridement of chondral injury. On 11/20/09, Dr. released the patient from his care regarding the knee. On 11/24/09, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 6% whole person impairment rating. Chiropractic therapy was performed with Dr. on 02/26/10. An FCE with Mr. on 03/03/10 indicated the patient functioned at the sedentary-light physical demand level. An MRI of the lumbar spine interpreted by Dr. on 04/07/10 showed mild hypertrophic change at L4-L5 and moderate hypertrophic changes with neuroforaminal narrowing at L5-S1. On 05/21/10, Dr. prescribed Hydrocodone, Ultram, Cymbalta, and Motrin and also noted the patient was pending a chronic pain management program. An EMG/NCV study interpreted by Dr. on 06/08/10 was unremarkable. On 07/07/10, Dr. advised against further treatment other than medication and recommended a walking and home exercise program. On 08/20/10, Dr. prescribed Hydrocodone, Ultram, Cymbalta, and Motrin and also recommended a mental health evaluation. Based on an FCE with Mr. on 09/02/10, a work conditioning program was requested. On 09/03/10, Dr. provided a preauthorization request for 80 hours of the work hardening program. Work conditioning was performed with Dr. on 09/10/10, 09/13/10, 09/14/10, 09/15/10, and 09/16/10. On 09/22/10, Dr. wrote a letter of non-authorization for 80 hours of the work hardening program. On 09/29/10, Dr. wrote a request for reconsideration. On 10/07/10, Dr. also wrote a letter of non-authorization for the work hardening program.

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

The claimant has already completed 30 hours of work conditioning. The Official Disability Guidelines (ODG) does not endorse over a total of 80 hours for work conditioning and therefore, a total of 110 hours would be excessive. Furthermore, having already completed her recommended work conditioning, further work conditioning is neither reasonable nor necessary at this time. There is no medical documentation provided to justify the continuation of work conditioning. This section also states that a diagnostic interview with a mental health professional is necessary prior to admission of a work conditioning program. This did not appear to have occurred based on the records provided. Additionally, in his 07/07/10 RME, Dr. noted there was symptom magnification and he did not feel any further treatment, other than weight loss and a home exercise program, was appropriate. Based on this information and the criteria set forth by the ODG, the requested 80 hours of work conditioning is neither reasonable nor 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
- 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)