

Notice of Independent Review Decision

**PEER REVIEWER FINAL REPORT**

**DATE OF REVIEW:** 10/5/2010  
**IRO CASE #:**

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

10 sessions of a work conditioning program for 60 hrs

**QUALIFICATIONS OF THE REVIEWER:**

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)

10 sessions of a work conditioning program for 60 hrs Upheld

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Letter, dated 9/22/2010
2. Follow up visit by MD, dated 8/26/2010
3. Report of medical evaluation by Author unknown, dated 8/19/2010
4. Review of medical history and physical exam by MD, dated 8/19/2010
5. Report of medical evaluation by MD, dated 8/19/2010
6. Impairment rating report by Author unknown, dated 8/19/2010
7. Clinical note by Author unknown, dated 8/4/2010 to 8/11/2010
8. Clinical note by Author unknown, dated 8/4/2010 to 8/11/2010
9. Operative note by MD, dated 8/2/2010
10. Operative report by MD, dated 8/2/2010
11. Peer review division by, dated 7/15/2010
12. History note by MD, dated 7/8/2010
13. Prescription note by Author unknown, dated 6/24/2010
14. Follow up by, dated 5/25/2010
15. Letter by MD, dated 5/18/2010
16. Referral note by Author unknown, dated 5/18/2010 and 6/24/2010
17. History note by MD, dated 4/22/2010
18. Clinical note by Author unknown, dated 4/21/2010 to 8/11/2010
19. MRI of the lumbar spine without contrast by MD, dated 4/6/2010
20. Functional capacity evaluation by, dated 3/24/2010 and 7/15/2010

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21. Prescription note by Author unknown, dated 3/18/2010
22. Initial physical examination by, dated 3/16/2010
23. Work status report by Author unknown, dated 3/14/2010 to 8/23/2010
24. Follow up appointment scheduled by Author unknown, dated 3/12/2010
25. X rays lumbar spine by MD, dated 3/11/2010
26. Letter of medical necessity by Author unknown, dated unknown,
27. Muscle testing and range of motion by, dated unknown,
28. Physical medicine post steroid injection by, dated unknown,
29. Independent review organization by, dated 9/17/2010
30. Fax page dated 9/17/2010
31. Fax page dated 9/17/2010
32. Case assignment by, dated 9/17/2010
33. Letter by, dated 9/16/2010
34. Review organization by Author unknown, dated 9/16/2010
35. Independent review organization by Author unknown, dated 9/16/2010
36. Fax page dated 9/16/2010
37. Adverse determination by Author unknown, dated 9/1/2010
38. Utilization review determination by Author unknown, dated 8/18/2010
39. History note by, dated 8/18/2010
40. Letter by, dated 8/16/2010
41. Letter by, dated 8/5/2010
42. Functional capacity evaluation by Author unknown, dated 7/15/2010
43. Appeal letter for medical treatment by, dated 5/25/2010
44. Muscle testing and range of motion by, dated 5/24/2010
45. Letter by MD, dated 5/18/2010
46. Form by Author unknown, dated 5/5/2010
47. History note by MD, dated 4/22/2010
48. Follow up by, dated 4/14/2010 and 5/25/2010
49. History note by MD, dated 4/13/2010
50. Electrodiagnostic results by Author unknown, dated 4/13/2010
51. MRI of the lumbar spine without contrast by MD, dated 4/6/2010
52. Initial physical examination by, dated 3/16/2010
53. Nursing discharge instruction by Author unknown, dated 3/14/2010
54. X ray lumbar spine 2 view by MD, dated 3/11/2010
55. Functional capacity evaluation by, dated 3/11/2010
56. Form by Author unknown, dated unknown
57. Patient's current medication by Author unknown, dated unknown

#### **INJURED EMPLOYEE CLINICAL HISTORY [SUMMARY]:**

This injured employee is a male who was injured while at work. X-rays of the lumbar spine dated xx/xx/xx showed evidence of a probable subacute compression fracture at T12. Clinical note dated xx/xx/xx reported that the injured employee sustained injury when he was picking up cement and felt a popping sensation in his low back that radiated to his groin. He was recommended for physical therapy. Functional capacity evaluation dated 03/24/2010 reported that the injured employee's job physical demand level was rated as very heavy. The injured employee tested at the time of this evaluation at a sedentary physical demand level. MRI of the lumbar spine dated 04/06/2010 showed evidence of a posterior protrusion at L3-4 which caused slight right inferior neural foraminal stenosis. There was also a broad-base posterior protrusion at L4-5 which caused slight inferior neural foraminal stenosis bilaterally. At L5-S1 there was a posterior protrusion which abutted the thecal sac. There were also hypertrophic changes that were noted in the fact joints and these findings caused slight left inferior neural foraminal stenosis. Electrodiagnostic studies dated 04/13/2010 had findings consistent with a mild to moderate right L4 and L5 radiculitis.

The injured employee participated in physical therapy on 04/21/2010 and it appeared that he rated his pain as 8/10. Clinical note dated 04/22/2010 reported that on physical exam, the injured employee's range of motion in regards to flexion was measured at 30 degrees. There was pain with straight leg raising on the left. There was normal strength in the lower extremities and reflexes and sensation were intact. The injured employee was recommended for an epidural steroid injection. The injured employee participated in 3 sessions of physical therapy from 05/04/2010 to 05/18/2010. On 05/18/2010 the injured employee rated his pain as 8/10. Range of motion testing note dated 05/25/2010 reported that the injured employee's range of motion in the lumbar spine was measured at 34 degrees flexion, 22 degrees extension, 28 degrees right lateral flexion, and 26 degrees left lateral flexion. The injured employee continued to participate in physical therapy from 06/02/2010 through 06/24/2010. On 06/24/2010 the injured employee rated his pain as 8/10. Range of motion testing note dated 06/24/2010 reported that the injured

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employee's range of motion in the lumbar spine was measured at 39 degrees flexion, 27 degrees extension, 23 degrees right lateral flexion, and 25 degrees left lateral flexion. Functional capacity evaluation dated 07/15/2010 reported that the injured employee's job required physical demand level had not changed as it was still rated as very heavy. The injured employee at the time of this evaluation tested at a light physical demand level.

Operative note dated 08/02/2010 reported that the injured employee underwent an epidural steroid injection at L5/S1. The injured employee participated in additional sessions of physical therapy from 08/04/2010 through 08/11/2010. Range of motion testing note dated 08/09/2010 reported that the injured employee's range of motion in the lumbar spine was measured at 30 degrees flexion, 5 degrees extension, 10 degrees right lateral flexion, and left lateral flexion. Letter dated 08/16/2010 reported that the injured employee was recommended for a trial of ten sessions of a work conditioning program. The injured employee's physical demand level was also not verified by the employer. Letter dated 08/18/2010 reported that the injured employee had undergone behavioral testing with psychometric measurements to determine if work conditioning or work hardening was more appropriate. The injured employee was felt to be appropriate for work conditioning. It was stated that while participating in a multi-disciplinary work conditioning program the injured employee would participate 6-8 hours a day, 3-5 days a week as this offered the best chance for optimal recovery, control over pain and return to work for the injured employee. Report of medical evaluation on 08/19/2010 reported that the injured employee was stated to be a maximum medical improvement. On physical exam straight leg raising was negative and sensation was within normal limits. There was no evidence of atrophy and strength was rated as 5/5. Clinical note dated 08/26/2010 reported that the injured employee had an epidural steroid injection with relief. On physical exam there was improved range of motion, normal strength, and reflexes. A prior review dated 09/01/2010 stated that this request was denied secondary to the injured employee showing lack of improvement and evidence of plateauing with lower levels of care as well as a lack of an employer verified work demand level. Range of motion testing note dated 09/02/2010 reported that the injured employee's range of motion in the lumbar spine was measured at 45 degrees flexion, 15 degrees extension, right lateral flexion, and left lateral flexion.

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

Item in dispute - 10 sessions of a work conditioning program for 60 hours.

The documentation submitted for review does not support medical necessity of this request at this time. Established ODG guidelines recommend a maximum of 10 visits over 4 weeks for an equivalent of up to 30 hours for a work conditioning program. This request as stated would exceed established guidelines in regard to the number of hours of being requested. There does not appear to be any evidence of exceptional factors that would support continued work conditioning beyond what the guidelines recommend. The patient did not appear to reasonably progress throughout his course of therapy treatment. Additional sessions of physical therapy, to include participation in a work conditioning program for a duration beyond what guidelines recommend without evidence of steady and objective functional improvements, would not be appropriate. The recommendation is to uphold the previous denial.

**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 KNOWLEDGBASE
- 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)