

MAXIMUS Federal Services, Inc.
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Notice of Independent Review Decision

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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: October 18, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Ten (10) sessions of a Work Hardening Program.

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

M.D., Board Certified in Physical Medicine and 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)

Ten (10) sessions of a Work Hardening Program are not medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. Request for a Review by an Independent Review Organization dated 9/23/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 9/27/10.
3. TDI Notice of Assignment of Independent Review Organization dated 9/28/10.
4. TDI Notice to IRO of Case Assignment dated 9/28/10.
5. Letter from dated 10/1/10.
6. Patient medical records from Rehabilitation for the period of 5/25/10 through 9/17/10.
7. Letter from MD dated 9/17/10.
8. Letters from MD for the period of 10/5/09 through 8/15/10.
9. Patient medical records from MD for the period of 10/28/09 through 8/23/10.
10. Functional Capacity Evaluation for the period of 3/12/10 through 5/25/10.
11. Patient medical records from for the period of 1/5/09 through 1/19/09.
12. Texas Workers Compensation Work Status Report for the period of 1/21/09 through 8/17/10.
13. Patient medical records from Chiropractic and Associates for the period of 1/21/09 through 6/18/10.
14. Patient medical records from Pain Consultants for the period of 2/17/09 through 8/11/10.
15. Prescription from Medical dated 2/18/09.
16. Patient medical records from Imaging Center dated 3/17/09.
17. Patient medical records from MD dated 4/2/09.
18. Patient medical records from Surgical Center dated 4/17/09.
19. Patient medical records from MD dated 6/9/09.
20. Independent Medical Examination dated 6/18/09.
21. Patient medical records from MD dated 6/18/09.
22. Patient medical records from Orthopedic Group dated 8/17/09.
23. Intraoperative Neurophysiology Report dated 10/28/09.
24. Hospital records dated 10/28/09.
24. Denial documentation dated 10/1/10.

PATIENT CLINICAL HISTORY [SUMMARY]:

From the records provided, this case involves a male patient who was injured on the job on xx/xx/xx. On 5/25/10, the provider documented the patient is status post lumbar surgery performed on 10/28/09. The patient is also noted to have been treated with epidural steroid injections, oral pharmacotherapy, 16 sessions of return to work program, and 30 structured physical rehabilitation sessions with improvement followed by plateau.

On physical evaluation, the patient had an inability to perform lifting required for his former job and had decreased range of motion (ROM) and flexibility (lumbar 58 flexion, 15 extension, 20 left lateral flexion, and 18 right lateral flexion). The provider requested coverage for 10 sessions

(80 hours) of a work hardening program. The patient was willing to participate but had reported to his provider in March 2010 that he was retraining for a different type of work (i.e., working on computers).

The Carrier has denied the request for additional therapy indicating that the requested service is not medically necessary for treatment of the patient's physical capacity and function. The Carrier states that the patient has already had the service and had plateaued in his progress; therefore additional work hardening program is not medically necessary.

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

The goal of a work hardening program is to improve the functional capabilities of an injured worker such that he is able to return and perform the physical demands of the job.

In this case, the injured worker did not plan to return to his former job which he stated in a visit with his treating physician in March of 2010. In addition, he has already received therapy that was designed to increase his level of function and he was noted to have plateaued in his progress. Thus, it is anticipated that the additional work hardening services requested would not result in improved functional capabilities. The Official Disability Guidelines (ODG) does not support work hardening/conditioning for return to work but recognizes that there are special circumstances when it may be necessary. The ODG indicates that a modified duty return to work (RTW) program in lieu of a work hardening program is appropriate whenever possible. The ODG indicates that a work hardening program may be helpful when the RTW program is unavailable. In this case, the patient participated in a RTW program and reached a plateau in his rehabilitation. There is no indication from the records provided that he is likely to experience any meaningful results from participation in the proposed work hardening program.

For these reasons, the requested work hardening program has not been established to be medically necessary for management of this patient's medical condition.

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)