

# Core 400 LLC

An Independent Review Organization  
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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Mar/29/2011

**IRO CASE #:**

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

Work Hardening 5xWk x 2Wks

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

MD, Board Certified PMR and Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

Utilization review determination dated 01/24/11, 03/01/11

Operative report dated 07/09/10

Designated doctor evaluation dated 02/02/11

Note dated 01/06/11, 12/09/10, 11/11/10, 10/07/10

Work hardening preauthorization request dated 12/28/10

Psychosocial evaluation dated 12/14/10

Urine drug screen dated 12/09/10

Physical therapy daily note dated 10/04/10

Functional capacity evaluation dated 09/24/10

Official Disability Guidelines

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a XX year-old male whose date of injury is XX/XX/XXXX. On this date the patient injured his low back as he tried to push himself off a tank to move down the tank. The patient underwent right-sided discectomy/laminectomy on 07/09/2010. Functional capacity evaluation dated 09/24/10 indicates that the patient is not currently working. The patient's current PDL is medium and required PDL is heavy. The patient has completed 12 postoperative physical therapy sessions, per note dated 11/11/10. Psychosocial evaluation dated 12/14/10 indicates that the patient complains of low back pain. He reports difficulty sleeping. P3 depression scale T score is 61 and anxiety scale T score is 50. Diagnosis is pain disorder.

Designated doctor evaluation dated 02/02/11 indicates that on physical examination the patient was not asked to perform range of motion. Straight leg raising is 70 on the right, 90 on the left. Motor strength is rated as 5/5 throughout the bilateral lower extremities and deep tendon reflexes are 2+ and equal in the lower extremities. Patrick's sign is negative. He is taking Ibuprofen, Norco and a stool softener. The patient was determined to have reached

MMI as of this date with 5% whole person impairment.

Initial request for work hardening 5 x wk x 2 wks was non-certified on 01/24/11 noting that no documentation was provide regarding objective documentation of an adequate trial of physical or occupational therapy with improvement followed by plateau. The submitted records did not provide documentation of a specific defined return to work goal. The denial was upheld on appeal on 03/01/11 noting that the patient's current functional level is unknown as the most recent functional capacity evaluation was performed in September 2010. There is no indication that the patient has a job to return to.

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

Based on the clinical information provided, the reviewer finds that Work Hardening 5xWk x 2Wks is not medically necessary. The two previous denials are upheld. The patient underwent right-sided discectomy/laminectomy on 07/09/10; however, there is no comprehensive assessment of postoperative treatment completed to date or the patient's response thereto submitted for review. There is no recent functional capacity evaluation submitted for review to establish baseline levels of functioning, and current versus required physical demand level. There is no indication that the patient has a job to return to, and no specific, defined return to work goal was provided.

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

ACOEM-AMERICA 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)