

SENT VIA EMAIL OR FAX ON
Aug/04/2011

Applied Assessments LLC

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:

Aug/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening 5 X wk X 2 wks 10 days

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

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

OD Guidelines

1. Cover sheet and working documents
2. Utilization review determination dated 06/21/11, 07/14/11
3. Reconsideration dated 07/07/11
4. Office visit notes dated 11/01/10, 11/09/10, 11/11/10, 11/12/10, 11/15/10, 11/18/10, 11/19/10, 11/22/10, 11/23/10, 12/15/10, 01/14/11, 02/14/11, 03/14/11, 04/15/11, 05/16/11, 06/16/11
5. Environmental intervention note dated 06/21/11, 07/14/11
6. Operative report dated 01/20/11, 03/17/11
7. Electrodiagnostic report dated 12/17/10
8. Radiographic report dated 11/17/10
9. MRI lumbar spine dated 12/10/10
10. MRI of the left wrist dated 12/10/10
11. MRI of the left hand dated 12/10/10
12. Consultation dated 12/15/10
13. Initial comprehensive evaluation dated 11/17/10
14. Handwritten notes dated 12/28/10, 02/08/11, 03/24/11
15. Designated doctor evaluation dated 03/24/11
16. PPE dated 12/30/10, 02/11/11, 04/12/11, 05/19/11, 06/22/11
17. Initial behavioral medicine consultation dated 05/18/11

18. Assessment/evaluation for work hardening program dated 05/20/11
19. History and physical dated 05/27/11
20. Peer review dated 07/25/11
21. Work hardening program request dated 06/16/11

PATIENT CLINICAL HISTORY SUMMARY

The patient is a female whose date of injury is xx/xx/xx. On this date the patient was picking up a 3 year old child and had sharp pain in the right lower back that radiated to her leg. The patient was diagnosed with a lumbar strain. The patient underwent a short course of physical therapy. MRI of the lumbar spine dated 12/10/10 revealed 4 mm posterior disc protrusion at L5-S1, 2 mm posterior disc protrusion at L4-5, moderate degenerative facet joint hypertrophy from L2-3 through L5-S1. EMG/NCV dated 12/17/10 revealed bilateral sensory carpal tunnel syndrome, left median motor neuropathy, left ulnar sensory neuropathy and no evidence of cervical or lumbar radiculopathy. PPE dated 12/30/10 indicates that required PDL is medium and current PDL is sedentary. The patient underwent lumbar epidural steroid injection on 01/20/11 and 03/17/11. Designated doctor evaluation dated 03/24/11 indicates that the patient reached MMI as of this date with 5% whole person impairment. Diagnoses are reported as chronic mechanical low back pain syndrome, lumbar sprain/strain (resolved), and left wrist/hand dysfunction (by history). PPE dated 05/19/11 indicates that current PDL is sedentary. Initial behavioral medicine consultation dated 05/18/11 indicates that current medications include Ibuprofen, Tizanidine and Cymbalta. BDI is 21 and BAI is 30. Diagnoses are pain disorder and major depressive disorder. PPE dated 06/22/11 indicates current PDL is sedentary to light. Peer review dated 07/25/11 indicates that the patient may meet criteria for work hardening program.

Initial request for work hardening was non-certified on 06/21/11 noting that the guidelines state the patient cannot be a candidate for whom injections would be warranted. The attending did not know the response to prior epidural steroid injection. Reconsideration letter dated 07/07/11 reports that the second epidural steroid injection did not help her pain so additional injections were not requested. The denial was upheld on appeal dated 07/14/11 noting that the patient was not able to perform all required testing of the functional capacity evaluation which suggests that the request for work hardening is beyond the patient's abilities and does not meet guideline recommendations. No documentation was submitted regarding the patient's past therapy.

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

Based on the clinical information provided, the request for work hardening 5 x wk x 2 wks 10 days is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has undergone an adequate trial of physical therapy with improvement followed by plateau. There is no specific, defined return to work goal provided as required by the Official Disability Guidelines. As noted by the previous reviewer, the patient was unable to perform all required testing during the functional capacity evaluation, which calls into question the patient's suitability for work hardening program.

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

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES