

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: June 28, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work hardening program for 10 additional days/sessions (5 times per week for 2 weeks), 97545, 97546.

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)

The requested service, work hardening program for 10 additional days/sessions (5 times per week for 2 weeks), 97545, 97546, is medically necessary for treatment of the patient's medical condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained an injury to his cervical spine on xx/xx/xx while lifting a 60 pound bag. By report, an MRI of the cervical spine on 6/29/09 revealed mild broad based disc bulge at C3-4 with posterior osteophytic ridging and canal stenosis; large broad based posterior disc herniation at C4-5 with associated osteophytic ridging measuring 3.4-5 mm; canal stenosis with cord compression; mild broad based central and right side disc herniation at C5-6 with osteophytic ridging measuring 2-2.5 mm. The patient's provider indicates the patient has been treated with active therapy, injections and surgery. The patient has completed 10 sessions of a work hardening program with some improvement in his functional ability and with a decrease in use of opioid medications. The provider indicated that a 10-day extension of the work hardening program would improve the patient's strength, decrease his pain, decrease the risk of re-injury and decrease his impairment rating. The URA indicates the requested service is not medically necessary.

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

Review of the submitted evidence demonstrates that this patient meets Official Disability

Guidelines (ODG) recommendations for additional work hardening services. According to ODG, in order for treatment to be supported for longer than 1-2 weeks, there must be evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. The records provided demonstrate that the patient has participated in a prior work hardening program with benefit. The patient's physician noted that the patient's pain was not worse with increased strenuous activity, the patient reported he was no longer taking his prescribed opioid or muscle relaxant medication, and his strength had increased modestly but not enough to change to a higher physical demand level (PDL). Further, the medical records indicate that the patient is motivated to return to work. All told, the patient's past participation in work hardening resulted in the kind of progress that would be expected and an additional 10 days of work hardening is medically necessary to continue this progress and attempt to allow the patient to return to his prior level of work.

Therefore, I have determined that the requested work hardening program for 10 additional

days/sessions (5 times per week for 2 weeks), 97545, 97546, is consistent with ODG recommendations and is medically necessary for treatment of the 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)