



## Medwork Independent Review

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*NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION*  
*Workers' Compensation Health Care Non-network (WC)*  
*MEDWORK INDEPENDENT REVIEW WC DECISION*

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**DATE OF REVIEW: 06/21/2011**

**IRO CASE #:**

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

10 sessions of work conditioning for 6 hours per day (97545 x 1, 97546 x2)

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

Texas State Licensed MD Board Certified Anesthesiology & Pain Management physician

**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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Assignment of IRO 06/03/2011
2. Notice of assignment to URA 06/03/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 06/02/2011
4. Company Request for IRO Sections 1-3 undated
5. Request For a Review by an IRO patient request 06/01/2011
6. Letter of Medical Necessity 05/31/2011, PreAuthorization Request 05/23/2011, Letter of Medical Necessity 05/13/2011, 05/12/2011, Insurance Letter 05/10/2011, 05/03/2011, Medicals 04/15/2011, 04/13/2011, 04/12/2011, 04/11/2011, 04/06/2011, 04/05/2011, 04/04/2011, 03/30/2011, 03/22/2011, 03/01/2011, 02/17/2011, 11/12/2010, 06/15/2010, 06/14/2010, 05/13/2010, 04/26/2010.
7. ODG guidelines were not provided by the URA

**PATIENT CLINICAL HISTORY:**

Claimant was injured on the job on or about XX/XX/XXXX. He was given sessions of physical therapy. He saw a doctor who recommended lumbar epidural steroid injections; these were denied by the carrier. An MRI of the lumbar spine revealed a 3-mm bulge at L1-L2, which flattens the thecal sac. At the L4-L5 level there is a 5-mm subligamentous disc protrusion indenting the surface of the thecal sac and at L5-S1 a 3-mm annular disc bulge. There was also bilateral foraminal narrowing reported, associated with facet arthrosis. An EMG/NCV performed revealed lumbar



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radiculopathy affecting the L4 and L5 nerve roots. Review records indicate that the PDA level of the claimant's job is heavy and that the patient is unable to return to his job at this time. Orthopedic surgeon's notes indicate the patient has had considerable treatment, and conservative care has failed and the patient should accept his disability or opt for back surgery. Review request is for 10 sessions of work conditioning for 6 hours per day (97545 x1, 97546 x2).

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

Regarding work hardening, the current Official Disability Guidelines offers that the timeline for the program is "10 visits over 4 weeks equivalent to up to 30 hours." According to the records, this patient has already had this. The Official Disability Guidelines also state, "21) Repetition: Upon completion of a rehabilitation, e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program, neither reenrollment nor repetition of this same or similar rehabilitation program is medically warranted for the same condition or injury." The review records are not in support of the recommendations of the Official Disability Guidelines; therefore, the insurer's decision to deny the requested 10 sessions of work conditioning for 6 hours per day (97545 x1, 97546 x2) is upheld.

### **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)