



## Medwork Independent Review

5840 Arndt Rd., Ste #2  
Eau Claire, Wisconsin 54701-9729  
1-800-426-1551 | 715-552-0746  
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### *NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION Workers' Compensation Health Care Non-network (WC)*

**DATE OF REVIEW: 10/13/2011**

**IRO CASE #:**

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

Is a work-conditioning program times 80 hours for the low back medically necessary for this patient?

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

Texas State Licensed MD Board Certified Orthopedic Surgeon & Spine Surgeon

#### **REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]**

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. Texas Dept of Insurance Assignment 10/06/2011
2. Notice of assignment to URA 10/06/2011
3. Confirmation of Receipt of a Request for a Review by an IRO 10/05/2011
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 09/30/2011
6. Letter from Claims 09/29/2011, 09/26/2011, Letters 09/23/2011, Patient sheet 09/16/2011, Letter from Claims, 09/21/2011, Review Report 09/20/2011, Letters 09/16/2011, Assessment 09/13/2011, Patient Report 09/13/2011, Letters 09/01/2011, Evaluations 09/01/2011, Letter from Diagnostic 08/10/2011, Letters 07/12/2011, 06/30/2011
7. ODG guidelines were provided by the URA

#### **PATIENT CLINICAL HISTORY**



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The patient and the clinical data concerning this individual has been reviewed. Original date of injury is xx/xx/xxxx. The patient has been diagnosed as having a lumbar sprain. Despite 12 sessions of physical therapy, the patient's FCE documents that his current physical demand level is light and that his job requires medium.

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

There has been a request made for a work-conditioning program. Specifically, however, the request is for 80 hours.

Official Disability Guidelines recommend up to 10 work-conditioning sessions over 4 weeks. This would be 30 hours in total.

The request for 80 hours of work conditioning is unreasonable and certainly not within Official Disability Guidelines; therefore, the previous adverse determination should be upheld.

### **ADDENDUM:**

Further to the last dictation concerning this request, the opportunity of reviewing additional medical records has been done.

The records from rehabilitation have been reviewed and the designated doctor evaluation indicating that his opinion was that the patient had reached maximum medical improvement as of August 26, 2011 has been reviewed as well.

After careful review of this additional information, the opinions that were previously expressed remain unchanged. The previous adverse determination should be upheld. There is insufficient documentation as to the necessity of 80 hours of work conditioning.

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

#### **ODG GUIDELINES MUST BE USED IN DECISION = PER TX RULE**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGBASE
- 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



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- 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)**