

Envoy Medical Systems, L.P.
1726 Cricket Hollow Dr.
Austin, TX 78758

PH: (512) 248-9020
FAX: (512) 491-5145

Notice of Independent Review Decision

DATE OF REVIEW: 9/15/11

IRO CASE #:

Description of the Service or Services In Dispute
Work Hardening 80 hours/10days: 5x2 weeks

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

Physician Board Certified in Physical Medicine and Rehabilitation

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- X Upheld (Agree)
Overturned (Disagree)
Partially Overturned (Agree in part/Disagree in part)

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

PATIENT CLINICAL HISTORY (SUMMARY):

Patient is a. In he stumbled over some rebar and had onset of acute back pain, later diagnosed as lumbar sprain. He apparently continued working through December and was laid-off work in January 2011. A February 3, 2010 MRI of the lumbar spine revealed some degenerative joint changes and some small central disk protrusions at L4-5 and L5-S1. He was later released to work but there was none available. He had physical therapy, about 16 sessions, and also six cognitive therapy counseling sessions. He had a functional capacity evaluation on 5-19-11. Current medications reported were approximately one Flexeril per day and one hydrocodone about once per week.

Analysis and Explanation of the DECISION INCLUDE clinical basis, Findings and Conclusions Used to Support the Decision.

Opinion: I agree with the benefit company's rationale and decision to deny the requested service.

The reconsideration examiner stated that "the claimant has apparently done well with individual counseling and is taking minimum medication. Because there is no clear return to work plan, the work hardening request is not consistent with ODG guidelines, and is not medically necessary at this time.

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)**