



14785 Preston Road, Suite 550 | Dallas, Texas 75254
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Notice of Independent Review Decision

DATE OF REVIEW: 6/18/2013

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening Program x 80 hours (Unit) Lumbar.

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

M.D. Board Certified in Occupational Medicine/Urgent Care Medicine.

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

| Document Type | Date(s) - Month/Day/Year |
|--|--|
| Texas Department of Insurance Notice of Case Assignment | 6/29/2013 |
| Review Determination Letters Notice Of Disputed Issue(s) And Refusal To Pay Benefits Request For Certification | 5/01/2013-5/20/2012 10/02/2012 7/04/2012 |
| Requests for Pre-Authorization Patient Report of Work Duties Initial Assessment Functional Capacity Evaluation Work Hardening Goals/Termination Criteria Or Treatment Initial Behavioral Medicine Evaluation Assessment For Work Hardening Program Work Hardening Program Pre-Authorization Request | 5/16/2013-5/20/2013 3/06/2013 3/12/2013 3/12/2013 3/06/2013 1/07/2013 3/06/2013 4/26/2013 |
| Follow Up | 3/30/2013 |



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| MRI Spine Lumbar W/O Contrast Report | 9/18/2012 |
| Clinical Notes | 8/15/2012 |

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient, a female, who filed a claim for low back pain reportedly associated with a work-related injury of xx/xx/xx.

Thus far, she has been treated with 16 sessions of physical therapy; transfer of care to and from various providers in various specialties; a functional capacity evaluation of March 12, 2013 (notable for comments that the patient tests in the medium physical demand level); unspecified amounts of individual psychotherapy; and extensive periods of time off of work. The patient also carries a diagnosis of active bipolar disorder.

Documents reviewed include:

- A handwritten work-status report of March 6, 2013 which suggests that the patient had returned to regular duty work effective October 24, 2012.
- A functional capacity evaluation report of March 12, 2013, suggesting that the patient is on hydrochlorothiazide, Zestril, Mobic, Seroquel, Tramadol, and Trileptal.

It is suggested that the patient tests within the light physical demand level. It is stated that the patient did not perform certain tasks due to fear, anxiety, and pain.

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

Per ODG references, the requested Work Hardening Program x 80 hours (Unit) Lumbar is not medically necessary.

As suggested by ODG, acceptance to the work hardening program should be contingent upon completion of a screening evaluation with details of the history of injury, the history of treatment for the injury, work status, employability, and/or diagnoses. In this case, there is no clear documentation of what the operating diagnosis is. There is no clear description of the patient's work status. One report of March 2013 suggested that the patient has returned to work while another report suggested that the patient is off of work. There is no clear-cut evidence of a valid work-related musculoskeletal deficit that requires work hardening to recuperate or rehabilitate. It appears that the patient is self-limited in certain behaviors and job tasks due to pain, anxiety, and other issues on the FCE. ODG criteria for admission to the proposed work hardening program have not been met. Therefore, the request is not medically necessary.



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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 KNOWLEDGE BASE
- 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