

DATE: 01.05.15

Notice of Independent Review

REVIEWER'S REPORT

DATE NOTICE SENT TO ALL PARTIES: 01.05.15

IRO CASE #:

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

M.D., F.A.C.S., board certified orthopedic surgeon with extensive experience in the evaluation and treatment of patients suffering low back pain

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening, 80 hours, lumbar

REVIEW OUTCOME:

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

- Upheld** (Agree)
 Overtured (Disagree)
 Partially Overtured (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
847.2	97545 97546		Preauth.				Xx/xx/xx		Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The claimant is a female who suffered a strain of her lumbar spine on xx/xx/xx. Current medications include Flexeril, Norco, and tramadol. She has undergone MRI scan of the lumbar spine, revealing degenerative disc disease at L4-L5 and L5-S1. Her complaints of pain are primarily left-sided lumbar and left flank. She does have radiation into the left lower extremity. The claimant has been treated with medications, physical therapy, and facet joint injections. She has persistent pain. Her pain interferes with her activities of daily living. She has difficulty sleeping. She is currently unable to drive more than 20 minutes without producing severe pain. It is reported that she is unable to drive adequately to return to work. She has Functional Capacity Evaluations, which indicate that she is functioning at a sedentary physical demand level and that her work requires moderate physical demand functioning. She has been certified as having received all noninvasive, nonoperative forms of management and is not a surgical candidate. Work hardening has been recommended in anticipation of a return to work recommendation. This recommendation and request for preauthorization have been denied on two occasions, primarily because there are forms of physical therapy including acupuncture and chiropractic care and additional physical therapy, which have not been accomplished. Furthermore, her symptoms are severe and a return to work recommendation does not appear to be imminent. She has a mental health examination evaluation, which concluded that she was suffering from depression and anxiety with fear of further injury. It would appear that she does not meet the criteria established for the inclusion in a work hardening program. The prior denials of this request of preauthorized work hardening programs were appropriate and should be upheld.

ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The criteria for the inclusion in a work hardening program are available in prior letters of denial and through the Official Disability Guidelines 2014 low back pain chapter. This claimant would be unable to return to work taking the kinds of medications that she is taking. Furthermore, she is unable to drive adequately to return to work and she has not completed all reasonable conservative care.

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 judgment, clinical experience and expertise in accordance with accepted medical Standards
- Mercy Center Consensus Conference Guidelines
- Milliman Care Guidelines
- ODG-Office 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)