SIRO

Specialty Independent Review Organization

**DATE OF REVIEW:** 04/13/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**
The services under dispute include a work conditioning program (97545 and 97546).

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**
The reviewer is a Doctor of Chiropractic with greater than 10 years of experience in this field.

**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)

The reviewer agrees with the previous adverse determination as it relates to all care under review.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**
Records were received and reviewed from the URA and from the requestor. Records from the provider include the following: 4/3/07 letter from, daily progress and therapy notes from 11/14/04 through 11/15/06, 11/22/06 and 12/6/06 Healthcare Systems Re-eval forms, FCE of 12/29/06 and 12/29/06 evaluation by LPC.

Records from the URA include the following (in addition to any previously mentioned records): 2/6/07 denial by MD, 1/30/07 request for appeal letter, 1/11/07 review by MD, 1/3/07 precert request letter, 2/2/07 report by MD, 7/13/06 report by MD, 7/7/06 note from MD, form TWCC 73, TWCC 69 and report of 7/7/06 by MD, 7/3/06 right wrist MRI, 6/3/06 left wrist MRI and a 1/31/07 Preauth Flow sheet.

**PATIENT CLINICAL HISTORY [SUMMARY]:**
The above-mentioned patient was injured on while performing duties as a packer for. She has gone through passive and active therapeutic programs for many months. She switched treating doctors from to DC. The examination by Dr. indicates that this injury has yielded bilateral tendonitis. The MRI of the right wrist indicates a TFC tear distal to the ulnar styloid process (chronic) while the left wrist scan notes a suspected chronic TFC tear. The carrier's reviewer is recommending continued testing.

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

The reviewer notes that based upon the patient's presentation and lack of progression after physical therapeutic treatments that she is not currently a candidate for a return to work program. Because it is not likely that she will improve sufficiently to return to work on completion of the program. She should be evaluated by a board certified hand surgeon to determine future treatment. The ODG's indicate that treatment cannot be approved that exceeds 12 visits over eight weeks for this diagnosis. The reviewer indicates that this patient has likely not improved as she requires further testing and treatment as per the carrier's reviewing physicians, Dr. recommendation.

The entrance criteria for a return to work program as per DWC include the following:

1. Persons who are likely to benefit from the program.
2. Persons whose current levels of functioning due to illness or injury interfere with their ability to carry out specific tasks required in the workplace.
3. Persons whose medical, psychological or other conditions do not prohibit participation in the program.
4. Persons who are capable of attaining specific employment upon completion of the program.

This patient does not meet number 1 or number 4 at this time. As per the reviewer's opinion, she is not likely to benefit enough to allow her to gain specific employment. As it has been multiple doctors' opinion, that she will be forced to obtain a more light duty work because of her injuries.

The reviewer finds it interesting that the MMI report by Dr. gave the patient a 0% impairment rating but did not document any form of examination to determine this impairment. The reviewer indicates that the rating may be correct; however, it is not as per TWCC Guidelines to not perform an examination of the injured area.

**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)**