

Clear Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd. Suite 337-117
Austin, TX 7831

DATE OF REVIEW:

MARCH 31, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Comprehensive interdisciplinary functional restoration program for four weeks

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

Board-certified Internal 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)

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

Notification of Case Assignment, Medical Records from Requestor, Respondent, Treating Doctor (s), including Drs. dated 5/14/03 to 12/15/03 and 10/31/06-2/8/07, dated 12/24/03 to 10/12/06, radiographic imaging studies 2/27/07, procedure notes 1/22/07, and carrier correspondence.

PATIENT CLINICAL HISTORY [SUMMARY]:

The Patient injured her low back while lifting. MRI April 2003 showed degenerative changes and multiple disc bulges. CT-myelogram July 2004 showed disc protrusions and facet disease. She has been treated with physical therapy, medications, and multiple injections (epidural, facet, and trigger point)

with little improvement in her symptoms. Recent evaluations show deficits in objective physical parameters as well as significant subjective symptoms.

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

The Patient injured her low back and has not responded to a multitude of interventions. She has developed chronic pain. Evaluation reveals deficits in objective parameters. The medical literature supports the use of multidisciplinary functional restoration programs in chronic low back pain. These programs have been shown to improve objective physical parameters, subjective symptoms, and increase the likelihood of returning to work.

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)