**DATE OF REVIEW:** 05/31/07

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**:
Sixty-five additional hours of functional restoration.

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**
D.C., D.O., M.S., Board Certified

**REVIEW OUTCOME:**
"Upon independent review, I find that the previous adverse determination or determinations should be (check only one):

__X __Upheld (Agree)
_____Overturned (Disagree)
_____Partially Overturned (Agree in part/Disagree in part)

**INFORMATION PROVIDED FOR REVIEW:**
1. Request for review by an independent review organization dated 05/09/07
2. Report dated 05/08/07 from treating doctor (TD)
3. Report dated 05/04/07 from TD
4. Report dated 04/25/07 from TD
5. Report dated 04/19/07 from TD
6. Report dated 03/14/07 from TD
7. Report dated 02/21/07 from TD
8. Report dated 02/16/07 from TD; report references disc herniation at the C5/C6 level along with a negative EMG. The note indicated she had undergone four months of reconditioning therapy three times weekly. It was determined that she did not require any further diagnostics or invasive procedures or anything other than a home exercise program. He indicated she could return to a sedentary light form of work, which was indicated as insufficient for her current job demands. Reference was also made to a referral to Dr. in January 2007 who felt she was not at maximum medical improvement and recommended additional treatment.
9. Results of a Quantitative Functional Re-evaluation dated 02/20/07; physical demand of her job was listed as light. The physical therapist and occupational therapist felt that she tested at the sedentary to light level, which they state "meets physical demand level of job of injury. However, she had difficulty with static holding, grasping, repetitive overhead movement, and twisting with her right upper extremity, and these would need to be restricted."

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10. Assessment from L.P.C. dated 02/21/07; at that time her current medications consisted of ibuprofen.
11. Letter dated 05/17/07
12. Re-review of the ODG-DWC Guidelines for chronic pain programs
13. In a congruent review progress documentation of 04/13/07, reference was made to a global assessment of functioning increasing from 49 to 57 with a resolution of her symptoms of depression from 14 to 8, symptoms of anxiety had decreased from moderate to minimal level, and the fear of pain and re-injury had decreased from moderate to minimal level. She was demonstrating a greater commitment to psychological, social and/or vocational productivity and responsibility and verbalizing decreased focus on self-concept and lifestyle of disability. Sleep disturbance had decreased from moderate level to minimal. Range of motion and muscle strength had shown marked improvement, while her reaching ability, carrying ability, and grip/pinch also showed marked improvement along with pain management.

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The injured employee sustained a work-related injury on or about xx/xx/xx involving her cervical spine while working. She underwent four months of rehabilitation and 105 hours of the Program. She had a negative EMG study with positive MRI scan for herniated C5/C6 disc.

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

The injured employee appears to have improved over the passage of time with therapeutic interventions to date. It appears based upon the concurrent review progress documentation that she has progressed to the point where she could return to her light duty activities. The physical obstacles to returning to work that were noted on 02/20/07 would appear to have improved sufficiently to allow her to return to work. I believe the distillation of the medical records reviewed would support that she should be able to perform an independent home exercise program without the need of formal rehabilitation efforts at the facility beyond the 105 hours already provided.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**
*(Check any of the following that were used in the course of your review.)*

_____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.
__X __Medical judgement, clinical experience and expertise in accordance with accepted medical standards.
_____Mercy Center Consensus Conference Guidelines.
_____Milliman Care Guidelines.
__X___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 national accepted medical literature (provide a description).
_____Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)

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