

MEDICAL REVIEW OF TEXAS

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DATE OF REVIEW: **MAY 29, 2007**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 sessions of work conditioning program.

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

MD, Board Certified in Family Practice

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

- denial letters (4/16/07)
- Clinical notes from Dr. (1/4/07)
- Notes from Dr.
- Letter from attorney (5/16/07)
- DDE from Dr. (3/19/07)
- FCE (4/4/07)
- Note from Dr. (1/16/07)
- Records from (8/31/06, 9/20/06, 12/7/06)
- Peer Review (8/21/06)
- Records from Drs. (6/26/06)

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient sustained injuries on xx/xx/xx. She was treated with physical therapy, medications, ESI, comprehensive pain management program, and chiropractic care. Condition complicated by moderate depression and severe anxiety. Request for work conditioning program was denied.

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

THIS PATIENT HAD EXTENSIVE AND COMPREHENSIVE TREATMENT AND STILL HAS SIGNIFICANT PHYSICAL AND PSYCHOLOGICAL SYMPTOMS FROM HER INJURY OVER ONE YEAR AGO. A WORK CONDITIONING PROGRAM WOULD BE REDUNDANT AND DUPLICATIVE SERVICES SINCE THE PATIENT HAS ALREADY COMPLETED A COMPREHENSIVE WORK HARDENING PROGRAM.

IN ADDITION, SHE HAS SIGNIFICANT PSYCHIATRIC SYMPTOMS THAT SHOULD BE ADDRESSED PRIOR TO ENTERING ANOTHER INTENSIVE PROGRAM. LASTLY, THE PROBABILITY OF FUNCTIONAL OR SYMPTOMATIC IMPROVEMENT FROM THE REQUESTED SERVICES IS MINIMAL AFTER THE EXHAUSTIVE TREATMENTS THE PATIENT HAS RECEIVED SINCE HER INJURY ON XX/XX/XX. THEREFORE, THE PRIOR DECISION IS UPHELD.

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)