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DATE OF REVIEW: 05-17-07

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Program – Ten (10) Sessions

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

Certified by the American Board of Psychiatry & Neurology
General Certificate in Psychiatry

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.

| Injury Date | Claim # | Review Type | ICD-9 DSMV | HCPCS/NDC | Upheld/Overturn |
|-------------|---------|-------------|------------|-----------|-----------------|
| xx/xx/xx | | | | | |

IRO NOTICE OF DECISION - WC
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INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determinations (Report dates 03-13-07 and 03-29-07)
Medical Evaluation Report (06-05-06)
Addendum letter (04-12-07)
Physician Psychological Evaluation (09-13-06)
Evaluation Findings (02-20-07)
Pre-certification Request (03-08-07)
Request for an Appeal (03-23-07)
Dispute letter (03-30-07)
Daily Progress & Therapy Notes (02-09-07, 02-12-07, 03-02-07, 03-05-07)
Physical Performance Exam (01-23-07)

PATIENT CLINICAL HISTORY [SUMMARY]

This is a injured worker (IW) who had been employed as a flooring technician. While at work on xx/xx/xx, the IW fell down some concrete stairs and fractured the left ankle. Despite medical and surgical intervention as well as a course of physical therapy, the IW remains incapacitated with chronic ankle pain and limited mobility. In the context of ongoing pain, disability, and loss of income, the IW is understandably depressed and anxious.

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

The injured worker suffered a clear-cut injury at work nearly two years ago and still experiences substantial pain and disability. In this context, denial of the requested 10 days of outpatient pain management would fall substantially below the standard of care for this condition. Accordingly, I recommend approval of the requested treatment.

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)**