

C-IRO, Inc.
An Independent Review Organization
7301 Ranch Rd. 620 N, Suite 155-199
Austin, TX 78726

DATE OF REVIEW: OCTOBER 9, 2007

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

20 Sessions of Work Hardening Program (5xweek/4weeks)

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

M.D., board certified anesthesiologist from the American Board of Anesthesiology with Certificate of Added Qualifications in Pain Management granted by the American Board of Anesthesiology.

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.

There is no medical necessity for twenty sessions of work hardening (5xweek/4weeks).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Adverse Determination Letters, 8/13/07, 8/27/07
Official Disability Guidelines and Treatment Guidelines
Dr. 6/20/07, 7/13/07, 9/21/07
Evaluation, LPC, 6/14/07
Psychosocial History, LPC, 7/31/07
Dr., 4/24/07, 5/10/07

Medical & Rehab, PT Notes, 3/6/07, 4/4/07, 4/6/07
DC, 2/15/07, 2/26/07, 5/11/07
Functional Abilities Evaluation, 2/22/07
Testing, Dr. 8/7/07

PATIENT CLINICAL HISTORY [SUMMARY]:

This injured worker sustained a head and neck injury at work and had psychotherapy, medication management, chiropractic care, and physical therapy. There is an indication that she is depressed.

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

Per ODG 10th Edition, outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met:

1. An adequate and thorough evaluation has been made. This criteria has not been met. The evaluation by a masters level therapist was cursory and did not include the usual evaluation instruments such as an MMPI.
2. Previous methods of treating the chronic pain have been unsuccessful. This criteria has been met.
3. The patient has a significant loss of ability to function independently, resulting in the chronic pain. This criteria has been met.
4. The criteria is not a candidate where surgery would clearly be warranted. This is not clearly stated in the medical records, but it appears that this criteria has been met.
5. The patient exhibits motivation to change and is willing to forego secondary gains including disability payments to affect this change. In the brief psychological evaluation, there a statement that the patient's motivation is low. Therefore, this criteria has not been met.

Per ACOEM Guidelines, 2004, Chapters Five and Six, stress the need for diagnostic clarity and individualized time limit and treatment plans with clear functional goals as a cornerstone of effective treatment. This criteria has not been met. The diagnostic methods are cursory, and there is no individualized treatment plan. There is only a boiler plate generalized statement, vague goals with no specific goals related to this patient. Therefore, these criteria have not been met.

There is no medical necessity for twenty sessions of work hardening (5xweek/4weeks).

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)**