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Notice of Independent Review Decision

AMENDED REPORT #2 – 7/30/2009

DATE OF REVIEW: 7/8/09

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The services under dispute include a work conditioning program of 20 sessions (97545 and 97546).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This provider has been practicing for greater than 10 years.

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)

The reviewer agrees with the previous adverse determination in full.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties: Dr. and .

These records consist of the following (duplicate records are only listed from one source): Dr. : 6/22/09 letter by Dr. , 6/1/09 letter by DC, 5/13/09 preauth request and 4/30/09 FCE.

: 6/23/09 letter, request for IRO review paperwork, LHL 009, 5/19/09 denial letter, 6/5/09 denial letter, 6/23/09 IRO summary report, DWC 1, PLN 11 7/14/08,

PLN 1 7/31/08, 6/16/08 associate statement, various DWC 73 forms, various handwritten forms from the 6/16/08 to 6/26/08, 6/17/08 radiology reports of the cervical and thoracic spine and left shoulder, DWC 6 reports 6/18/08 to 7/1/08, 6/21/08 shoulder MRI report, ER reports 7/1/08, 7/23/08 report by MD, 7/29/08 left wrist MRI and x-ray reports, 8/6/08 denial letter, (PRC) notes of 9/3/08 to 11/15/08, reports by MD 9/4/08 to 2/25/09, 9/5/08 report by MD, 10/1/08 denial letter, 10/29/08 letter of clarification request, 11/12/08 letter of clarification, 11/19/08 RME, 12/12/08 BRC, 2/18/09 CCH report, 4/7/09 DWC 69 and exam report, 5/15/09 preauth fax sheet, 6/2/09 request for recon fax sheet, 8/9/07 left shoulder MRI report, 9/24/07 cervical and lumbar CT reports, 2/28/08 to 4/22/08 notes by , MD, 2/28/08 neurodiagnostic report, EMG order undated, 4/22/08 brain MRI, 4/22/08 MRA carotid arteries report, 5/20/08 EEG report and 6/16/08 neurodiagnostic report.

We did not receive a copy of the ODG Guidelines from Carrier/URA.

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient was injured on xx/xx/xx while working for . The injury happened when a table collapsed which provoked a traction injury towards her left arm. A TDI BRC of 12/12/08 limits the extent of her claim to the left shoulder and wrist. The DDI placed her at MMI on 4/7/09 with 0% IR based upon inconsistent ROM and dynamometer testing.

Peer reviewers have apparently denied the work conditioning program due to DDE findings. They have also found her disability to be iatrogenic as she was taken off work by her providers with light duty available. She has been managed with 19 visits of PT.

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

The ODG indicates a threshold of 8 visits over 12 weeks to be recommended for a work conditioning program. The requestor is requesting 20 visits which falls outside of the recommended guideline. Therefore, this request cannot be granted based upon the medical records presented at this time.

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)**