MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71 **Austin, Texas 78735**
Phone: 512-288-3300 **FAX: 512-288-3356**

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-0555-01
Name of Patient:	
Name of URA/Payer:	St. Paul Fire & Marine Insurance
Name of Provider: (ER, Hospital, or Other Facility)	Pain & Recovery Clinic
Name of Physician: (Treating or Requesting)	Carter Outlaw, DC

January 23, 2006

An independent review of the above-referenced case has been completed by chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on the Division of Workers' Compensation Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Michael S. Lifshen, MD
Medical Director

cc: Pain & Recovery Clinic
David M. Griffith, DC
Carter Outlaw, DC
Division of Workers' Compensation

CLINICAL HISTORY

Documents Reviewed Included the Following:

1. 07/21/05 Initial Evaluation for ___ right elbow injury
2. 07/28/05 Initial Evaluation for ___ left shoulder injury
3. Correspondence, examination and treatment records from the provider
4. Independent Medical Examination
5. Carrier Reviews
6. NCV/EMG Reports
7. Reports from Gregory L. Lilly, M.D.
8. Reports from TREK MD Mobile Medical Diagnostics
9. Psychological evaluation and reports
10. Report from Bruce Miller, M.D.
11. Report from Michelle Hall, P.A.C.
12. Reports from Mario Bustamante, M.D.
13. Shoulder Rehabilitation Treatment Logs
14. Reports from Gonzaba Medical Group
15. Functional Abilities Evaluation
16. Gulf Coast DME Prescription for EMS Device

The claimant was initially evaluated by the provider on 07/21/05 for a right elbow condition with a date of injury of ___. The claimant was then initially evaluated by the provider on 07/28/05 for a left shoulder condition with a date of injury of ___. For the left shoulder injury, the claimant has undergone physical medicine treatments, diagnostic imaging, surgery and psychological sessions.

REQUESTED SERVICE(S)

Prospective request for 1 unit WH (97545) and 6 units WH (97546) daily, 8 hours, for 4 weeks.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

Current medical literature states, "…there is no strong evidence for the effectiveness of supervised training as compared to home exercises. There is also no strong evidence for the effectiveness of multidisciplinary rehabilitation as compared to usual care." [1] The literature further states "…that there appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities..." [2] And a systematic review of the literature for a multidisciplinary approach to chronic pain found only 2 controlled trials of approximately 100 patients with no difference found at 12-month and 24-month follow-up when multidisciplinary team approach was compared with traditional care.[3] Based on those studies, the medical necessity of the proposed work hardening program is not supported.

Additionally, the previously attempted active rehabilitation treatments and psychological sessions had within them the self-help strategies, coping mechanisms, exercises and modalities that are inherent in and central to the proposed work hardening program. In other words and for all practical purposes, much of the proposed program has already been attempted and failed. Therefore, since the patient is not likely to benefit in any meaningful way from repeating unsuccessful treatments, the proposed work hardening program is not medically necessary.

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[1] Ostelo RW, de Vet HC, Waddell G, Kerchhoffs MR, Leffers P, van Tulder M, Rehabilitation following first-time lumbar disc surgery: a systematic review within the framework of the cochrane collaboration. Spine. 2003 Feb 1;28(3):209-18.

[2] Karjalainen K, Malmivaara A, van Tulder M, Roine R, Jauhiainen M, Hurri H, Koes B. Multidisciplinary biopsychosocial rehabilitation for neck and shoulder pain among working age adults. Cochrane Database Syst Rev. 2003;(2):CD002194.

[3] Karjalainen K, et al. Multidisciplinary rehabilitation for fibromyalgia and musculoskeletal pain in working age adults. Cochrane Database of Systematic Reviews 2000;2.

Certification of Independence of Reviewer

As the reviewer of this independent review case, I do hereby certify that I have no known conflicts of interest between the provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

YOUR RIGHT TO APPEAL

If you are unhappy with all or part of this decision, you have the right to appeal the decision. The decision of the Independent Review Organization is binding during the appeal process.

If you are disputing the decision (other than a spinal surgery prospective decision), the appeal must be made directly to a district court in Travis County (see Texas Labor Code §413.031). An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. If you are disputing a spinal surgery prospective decision, a request for a hearing must be in writing and it must be received by the Division of Workers' Compensation, Chief Clerk of Proceedings, within ten (10) days of your receipt of this decision.

Chief Clerk of Proceedings
Division of Workers' Compensation
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 24th day of January, 2006.

Signature of IRO Employee: _____
Printed Name of IRO Employee: Cindy Mitchell