

MEDICAL REVIEW OF TEXAS

[IRO #5259]

10817 W. Hwy. 71

Phone: 512-288-3300

Austin, Texas 78735

FAX: 512-288-3356

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TDI-WC Case Number:	
MDR Tracking Number:	M2-06-1001-01
Name of Patient:	
Name of URA/Payer:	ARCFI
Name of Provider: (ER, Hospital, or Other Facility)	Injury One Treatment Center
Name of Physician: (Treating or Requesting)	Craig Cernosek, DC

April 20, 2006

An independent review of the above-referenced case has been completed by a 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: Injury One Treatment Center
Craig Cernosek, DC
Division of Workers' Compensation

CLINICAL HISTORY

Available documentation received and included for review consists of requestors position on pre-authorization for additional 20 sessions of CPM from Injury 1 Treatment Center, (Phil Bohart, MS, CRC, LPC), CPM records (10 day trial, Eval and treatment notes, Drs. Doyle (DC), Brewer (MD) Oishi (MD), Davis (DO) Cindrich (MD) Olmstead (MD), Morrison (MD), Cross (MD), Verner (MD), Plemmonds (MD) Schickner (MD), Walters (MD), Crockett 9DO), Cernosek (DC). X-ray (Lumbar spine) report, MRI (Lumbar spine) report, Electrodiagnostic report. Peer review denials.

Mr. ____, a 59-year-old male, injured his lower back while working as a maintenance man for _____ on _____. He underwent extensive conservative care, which then progressed to acquire a series of epidural steroid injections. Electrodiagnostics confirmed radiculopathy and he underwent a two level laminectomy and discectomy on 10/28/04, with some postsurgical complications. He continued with fairly significant pain complaints combined with functional compromise, underwent post-surgical rehabilitation including some individual psychotherapy sessions, then work hardening. Medications include Tizanadine, Carisprodol, Metformin and Cymbalta.,

He was referred for chronic pain management services and has undergone 10 sessions between 12/08/05 and 02/22/05. Outcomes reveal improvement across 75% of measured indices. ADL improvements were noted in grooming / hygiene, along with walking, standing and driving tolerance.

A functional assessment revealed some gains in strength and ROM, but he remained at a sedentary PDL. There is some pain behavior noted with some inconsistency during the exam.

The records indicate fair compliance with attendance, with satisfactory effort reported by the entire treatment team at the end of the trial sessions.

Change in the use of medication was undetermined.

REQUESTED SERVICE(S)

Chronic pain management program (97799-CP) X 20 sessions.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The patient has made demonstrable improvement including functional and psychological gains with the initial 10 CPM sessions. ACOEM guidelines⁽³⁾ suggest focus should be on functional improvement rather than on abolishing pain. The treatment goals for this patient are individualized, functional, objective and measurable.

Review of the documentation supplied supports the patient fulfills the criteria for establishing medical necessity for continuation.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

1/ CARF Manual for Accrediting Work Hardening Programs

2/ AMA Guides to the Evaluation of Physical Impairment, 4th Edition

3/. ACOEM Guidelines Ch. 6 pg 107 & 109

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 21st day of April 2006.

Signature of IRO Employee: _____

Printed Name of IRO Employee: Cindy Mitchell