

Notice of Independent Review Decision

IRO REVIEWER REPORT

DATE OF REVIEW: 08/28/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Functional restoration program – 10 sessions

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

The TMF physician reviewer is board certified in pain management with an unrestricted license to practice in the state of Texas. The physician is in active practice and is familiar with the treatment or proposed treatment.

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.

It is determined that the functional restoration program – 10 sessions is not medically necessary to treat this patient's condition.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Letter to TMF – 08/22/08
- Letter of determination– 07/11/08
- Letter– 08/07/08

- Report of MRI of the lumbar spine – 02/07/05, 10/31/07
- Report of Medical Evaluation – 07/23/07
- Report of designated doctor examination by Dr.– 07/13/07
- Follow-up consultation notes by Dr. – 07/14/05 to 03/04/08
- Progress notes by Dr. – 08/19/05 to 07/21/08
- ODG – TWC Treatment guidelines for Pain (Chronic) – no date
- Memorandum for request for approval of Functional Restoration – 07/07/08, 07/30/08
- Pain Outcomes Profile – 07/03/08
- Report of physical examination by Dr. – 05/06/08
- Functional Capacity Evaluation – 07/19/07
- History and physical with treatment plan– 07/07/08
- Report of lumbar discogram – 08/16/05
- Follow-up consultation notes by Dr. – 03/23/06 to 12/13/07
- Report of post-myelogram CT scan – 12/05/07
- Follow-up medical evaluation by Dr. – 11/18/05
- Initial consultation by Dr.– 01/27/05
- Information for obtaining review by an IRO – 08/15/08

PATIENT CLINICAL HISTORY [SUMMARY]:

This patient sustained a work related injury on xx/xx/xx when he fell into a tank and fell approximately 10 feet. The patient complained of low back pain and an MRI from 02/07/05 revealed a disc protrusion at L5-S1. The patient has been treated with medications as well as participation in a chronic pain management program.

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

A work up revealed that this patient has lumbar discopathy. A fusion as well as a spinal cord stimulator has been declined by the patient. In addition, a 20 day pain management program was completed in July of 2007. The ODG criteria #2 states that.....there is absence of other options likely to result in significant clinical improvement. This criterion has not been met. There are definite treatments that have been offered but the patient has declined.

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)