



Notice of Independent Review Decision

**DATE OF REVIEW:** 5/15/08

**Date Amended:** 5/21/08 &  
5/23/08

**IRO CASE #:**

**NAME:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Determine the appropriateness of the previously denied request for 10 sessions of a functional restoration/detox program (days 21-30).

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

Texas Licensed Physical Medicine and Rehabilitation/Pain Management Physician.

**REVIEW OUTCOME:**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- 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.

The previously denied request for 10 sessions of a functional restoration/detox program (days 21-30).

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- Nurse UM Summary dated 5/8/08.
- Review Request dated 5/2/08.
- Utilization Review Report/Letter dated 4/23/08, 4/22/08, 4/17/08.
- Concurrent Progress Report dated 4/17/08, 3/31/08.

- Fax Coversheet/Authorization Request dated 3/31/08.
- Functional Restoration/Outpatient Detoxification Program Evaluation/Request dated 2/11/08.
- Follow-Up Visit Note dated 2/6/08, 1/7/08, 1/2/08.

### **PATIENT CLINICAL HISTORY (SUMMARY):**

**Age:**

**Gender:** Female

**Date of Injury:**

**Mechanism of Injury:** Slip and fall injury while pulling a client out of the shower.

**Diagnosis:** Status post multiple failed back surgeries, recurrent lumbar radiculopathy, chronic arachnoiditis, and chronic low back pain syndrome.

### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

This female who sustained an industrial lower back injury. At that time, she was employed as a . The claimant was pulling a resident out of the shower when she slipped and fell, landing on her buttocks. She felt a pop in her low back and pain radiating to the right lower extremity. She failed conservative treatment and was referred to Dr. an orthopedic surgeon. She underwent several surgical procedures including L4-L5 fusion with orthopedic hardware. Subsequently, the hardware was removed. In total, she had four spine surgeries including placement and removal of two spinal cord stimulators.

The claimant had received extensive conservative treatment including physical therapy, medication, and a prior chronic pain management program two-three years ago. She has reported continuing increased pain and reduced therapeutic benefit from prescribed medications.

The physical examination findings regarding the claimant include physician's progress note by M.D., pain management specialist. He reports that the claimant is experiencing chronic low back pain with the following diagnosis: status post multiple failed back surgeries, recurrent lumbar radiculopathy, chronic arachnoiditis, and chronic low back pain syndrome. Most recently, Dr. was attempting to decrease her reliance on narcotic analgesic medication. She was previously prescribed OxyContin 40 mg 1 t.i.d., this was switched to Norco 10/325 mg 1 q.i.d.; however, the claimant did not experience satisfactory analgesia. Dr. began treatment of the claimant in October 2007. Because of his failure to decrease the narcotic analgesic medication, he referred the claimant for the functional restoration/detoxification program. The claimant was evaluated by that program on February 11, 2008, and found to be an appropriate candidate. The program would include a psychology evaluation and treatment cognitive-behavioral psychotherapy, biofeedback, and ongoing therapeutic exercise in

order to improve function and reduce reliance on prescribed medications by way of detoxification.

The claimant did complete 20 sessions of the chronic functional restoration/detoxification program and 10 additional sessions were requested and denied by both the primary, first level and at the appeal level. The initial non-authorization was dated April 22, 2008 and a subsequent appeal non-authorization is dated April 28, 2008.

Based upon the Official Disability Guidelines, up to 20 visits of a functional restoration program is supported and 10 additional sessions are under review. The submitted documentation indicated improved claimant-self awareness; however, she has had an increase in reliance upon prescribed medication and an increase in her BAI score. There was some subjective reduction in pain from 7 on a scale of 10, 5 on a scale of 10; however, this may be secondary to the increased use of oral medications by the claimant.

The Official Disability Guidelines section regarding functional restoration program and basically, it states that "treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." 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.
- (2) Previous methods of treating the chronic pain have been unsuccessful.
- (3) The patient has a significant loss of ability to function independently resulting from the chronic pain.
- (3) The patient is not a candidate where surgery would clearly be warranted.
- (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change.

This claimant meets the criteria as an outlier to the 20 session recommendation and an additional 10 days would be reasonable.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM – AMERICAN COLLEGE OF OCCUPATIONAL AND 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. Official Disability Guidelines (ODG), Treatment Index, 6<sup>th</sup> Edition, 2008. Pain section – Functional Restoration Programs and Chronic Pain Programs.

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR.

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE AND 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).