

# **RYCO MedReview**

## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 05/07/08

**IRO CASE #:**

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

Remaining 6 visits of functional restoration program

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

Board Certified in Orthopedic Surgery

### **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.

6 remaining visits of functional restoration – Upheld

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

Evaluation from M.D. dated 12/14/07, 01/09/08, 01/30/08, 02/22/08, 03/20/08, 04/02/08, 04/15/08

An unsigned Mental Health Evaluation dated 01/09/08  
Pride Quantitative Functional Evaluation Summary from, P.T. dated 01/09/08  
Request for Approval of Functional Restoration Program (Pre-Auth) dated 01/17/08,  
02/18/08, 03/27/08  
Concurrent Review Progress Documentation dated 02/18/08, 03/14/08  
PRIDE Quantitative FCE from P.T. dated 03/12/08  
Notification of Determination from M.D. dated 03/19/08, 03/20/08  
Reconsideration Letter from Dr. dated 03/25/08  
Letter of non-certification, according to the ODG, from dated 04/02/08  
The ODG Guidelines were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

An initial evaluation by M.D. dated 12/14/07 stated the current diagnostic impressions were chronic right lower leg dysfunction, severe deconditioning syndrome and severe chronic pain syndrome. A Mental Health Evaluation was performed by an unknown provider on 01/09/08 recommending the PRIDE program. A Quantitative Functional Evaluation Summary dated 01/09/08 from PT concluded the patient did not meet lifting requirements, was not able to independently use pain management techniques, had ROM and strength deficits, and positional tolerance for sitting, standing and climbing were not met due to pain. On 01/09/08, Dr. performed an Interdisciplinary Evaluation and recommended Lexapro, Klonopin, LodineXL, weaning of Darvocet, and beginning of the PRIDE program. On 01/30/08 Dr. discontinued the Klonopin and Lodine, recommended Ibuprofen and OTC Tylenol, and continued the Lexapro. Dr. requested 10 additional visits by telephone with M.D. on 02/22/08. A Quantitative FCE from P.T. dated 03/12/08 recommended the chronic pain management program be continued. M.D. wrote a letter of non-certification on 03/19/08 and 03/20/08 for 6 remaining visits. In a letter dated 03/20/08 Dr. stated he spoke with Dr. who had no objections to the 6 remaining visits. On 03/25/08 Dr. wrote a reconsideration letter for the remaining 6 visits. Dr. stated he spoke with M.D. on 04/02/08 regarding the remaining 6 visits and negotiated to a point of 4 additional visits. A letter of non-certification on 04/02/08 from Dr. for the 6 remaining visits. A reconsideration letter from Dr dated 01/15/08.

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

I do not feel the six additional visits are reasonable and necessary. The rationale for the claimant needing the extra visits is because he is only at a light functional capability after completing the twenty visits. However, the claimant should not require all six visits to reach the level for return to work status. The ODG guidelines recommends that twenty visits should be sufficient. I feel this is in line with ODG web-based guidelines as an outlier due to the physical findings currently noted.

**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)