



Professional Associates, P. O. Box 1238, Sanger, Texas 76266 Phone: 877-738-4391 Fax:
877-738-4395

Notice of Independent Review Decision

IRO REVIEWER REPORT – WC (Non-Network)

DATE OF REVIEW: 05/28/10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Initial functional restoration program times 80 hours

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.

Initial functional restoration program times 80 hours - Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 11/02/04, 11/16/04, 12/16/04, 12/24/04, 01/13/05, 02/08/05, 04/28/06, 05/03/06, 07/12/06, 10/16/06, 08/10/07, 08/27/07, 06/26/08, 01/15/09, 05/18/09, 06/23/09, 07/24/09, and 09/16/09

An MRI of the lumbar spine interpreted by M.D. dated 12/20/04

An operative report from M.D. dated 05/06/05

A Designated Doctor Evaluation with M.D. dated 04/06/06

An evaluation with M.D. dated 04/26/06

Evaluations with M.D. dated 01/21/09, 02/18/09, 03/20/09, 04/15/09, 05/14/09, 06/10/09, 07/07/09, and 08/03/09

Follow-up medication progress notes from M.D. dated 02/02/10, 02/16/10, 03/02/10, and 04/13/10

A pain outcomes profile scoring instrument form dated 03/23/10

An evaluation with an unknown provider (signature was illegible) at Wellquest Healthcare dated 03/26/10

An observed range of motion assessment from D.C. dated 03/26/10

A Functional Restoration/Opiate Step-Down Program Request from Dr. Ph.D., Dr., and Ph.D. dated 03/29/10

A letter of non-certification, according to the Official Disability Guidelines (ODG), from D.O. dated 04/06/10

A request for reconsideration letter from Dr. Dr. Dr. and Dr. dated 04/26/10

A letter of non-certification, according to the ODG, from M.D. dated 05/04/10

An undated treatment history of the patient

An undated IRO request from Dr., Dr., and Dr.

The ODG Guidelines were provided by the carrier/URA

PATIENT CLINICAL HISTORY

On 11/02/04, Dr. placed the patient on Skelaxin, Vicodin, and Mobic. An MRI of the lumbar spine interpreted by Dr. on 12/20/04 showed bilateral spondylosis at L5, mild disc desiccation at L5-S1, multilevel fat containing hemangioma, and a sacral cyst. On 05/06/05, Dr. performed an L5-S1 transforaminal lumbar interbody fusion, posterolateral fusion, and posterior segmental instrumentation. On 04/06/06, Dr. placed the patient at Maximum Medical Improvement (MMI) with a 10% whole person impairment rating. On 04/26/06, Dr. prescribed Amitriptyline and Verapamil. On 08/27/07, Dr. prescribed Verapamil, Amitriptyline, Soma, Atarax, Ativan, and Zoloft. On 06/26/08, Dr. prescribed Endocet, Verapamil, Amitriptyline, Soma, Crestor, Cymbalta, and Ambien CR. Duragesic was prescribed by Dr. on 07/24/09. On 03/02/10, Dr. ordered an MRI of the lumbar spine. On 03/29/10, Dr., Dr., Dr., and Dr. requested 20 days of a Functional Restoration Program. On 04/06/10, Dr. wrote a letter of non-certification for the Functional Restoration Program. On 04/13/10, Dr. wanted to appeal the denial of the program. On 04/26/10, there was a request for reconsideration of the Functional Restoration Program. On 05/04/10, Dr. also wrote a letter of non-certification for the Functional Restoration Program. An IRO was requested on an unknown date.

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

The patient has been out of work for over two years; that is the timeframe in which functional restoration programs have been shown to have their greatest efficacy. Further, the patient continues to be dependent upon narcotics. It does not appear that any plan has been in place to wean the patient from the narcotics. There is little evidence that the patient would respond favorably to a functional restoration program at this time. The test clinical data I have reviewed does not support the necessity of a functional restoration program. Therefore, the requested initial functional restoration program times 80 hours is neither reasonable nor necessary and the previous adverse determinations should be upheld.

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 AND KNOWLEDGE BASE
- 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)**