



Notice of Independent Review Decision

DATE OF REVIEW:

04/04/2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Functional Restoration Program (ten days).

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

Board Certified Physical Medicine and Rehabilitation/Pain Medicine Physician

REVIEW OUTCOME

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

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 requested Functional Restoration Program (ten days) is not medically necessary.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- TDI/DIVISION OF WORKERS' COMPENSATION referral form
- 03/15/11 MCMC Referral
- 03/15/11 Notice Of Assignment Of Independent Review Organization DWC
- 03/15/11 Notice To MCMC, LLC Of Case Assignment DWC
- 03/14/11 Confirmation Of Receipt Of A Request For A Review, DWC
- 03/09/11 Request For A Review By An Independent Review Organization
- 03/04/11 preauthorization determination appeal denial notice
- 02/25/11 Response to Denial Letter, M.S., L.P.C., Behavioral Health Associates
- 02/09/11 preauthorization determination denial notice
- 01/31/11 Patient Treatment Goals and Objectives, Functional Restoration Program
- 01/31/11 Initial Diagnostic Screening, M.S., L.P.C., and M.S., L.P.C. Intern, Behavioral Health Associates
- 01/31/11 Physician's Orders, Rehabilitation Center
- 12/17/10 Functional Capacity Evaluation, PT, ATC/PT, Orthopedic & Occupational Rehabilitation
- 10/15/10 Mental Health Evaluation Treatment Request, M.D.
- 10/08/10 report from M.S., L.P.C., Behavioral Health Associates
- 10/07/10 BHI 2 – Basic Interpretive Report
- 09/02/10 Follow Up Visit, M.D., Bone & Joint Clinic
- 10/25/94 Consultation, "JWS"
- Undated letter from M.D., Behavioral Health Associates

- Medications list
- Undated Mental Health Evaluation: Goals/Plan/Justification
- Note: Carrier did not supply ODG Guidelines.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured individual is a female with a left ankle injury on xx/xx/xx with two subsequent surgeries 11/18/1993 and 05/18/1994. She began to complain of lumbar pain as well subsequent to the second surgery. MRI and X-rays document multilevel degenerative changes of the lumbar spine without significant neural impingement or acute herniations, masses, etc. She was last actively involved in physical therapy (PT) in 1995. She has significant and notable complaints including primarily lumbar and psychosocial complaints (poor sleep, fatigue, irritability, financial and family stressors, etc.). She was recently referred on 09/02/2010 for a multidisciplinary chronic pain management program by Dr. to “reduce her weight, improve her chronic low back pain, and improve her sleep.” She had a comprehensive evaluation at Behavioral Health Associates for which a report was generated on 01/31/2011. It is notable for a self perception of severe disability and pain with associated depression and moderate sleep disturbance, elevated somatic and affective scales, and elevated Fear Avoidance Beliefs Questionnaire.

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

Per the Official Disability Guidelines (ODG) chronic pain section, the injured individual does not meet the criteria for a Functional Restoration Program for three reasons. Per the documentation she does not “show a motivation to change.” Secondly, and more importantly, per the ODG “if a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified.” Thirdly, per the ODG, a Chronic Pain Management Program or Functional Restoration Program is not indicated if “the diagnosis is primarily a personality or psychological condition without a physical component.”

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**