



**Notice of Independent Review Decision
IRO REVIEWER REPORT – WC (Non-Network)**

DATE OF REVIEW: 03/30/11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Functional Restoration Program 5 x Week Over 3 to 4 Weeks

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

Board Certified in Physical Medicine and Rehabilitation

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.

Functional Restoration Program 5 x Week Over 3 to 4 Weeks – UPHELD

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Lumbar Spine MRI, M.D., 03/24/04
- Nerve Conduction Studies, M.D., 08/04/04
- Neurosurgical Consultation, M.D., 06/18/05
- Designated Doctor Evaluation (DDE), M.D., 05/10/06
- Lumbar Spine MRI, M.D., 01/31/07
- Physician's Orders, 07/06/07
- Initial Diagnostic Screening, M.S., L.P.C., 12/17/08, 07/20/09
- Evaluation, M.D., 05/19/09, 07/07/09, 08/18/09, 10/01/09, 12/03/09, 03/16/10, 06/07/10, 08/26/10, 10/18/10, 11/09/10
- Lumbar Spine MRI, Dr. 06/09/09
- Radiographic Reading, 07/07/09, 08/18/09, 12/03/09
- Lower EMG and Nerve Conduction Study, M.D., 11/02/09
- Functional Capacity Evaluation (FCE), 01/19/10, 08/18/10, 01/19/11
- Lumbar Spine CT, M.D., 04/30/10
- Treatment Progress Update, 06/08/10, 11/30/10, 01/27/11
- Treatment Progress Note, 07/29/10, 08/04/10, 08/26/10
- Basic Interpretive Report, Unknown Provider, 09/15/10
- Functional Restoration Program Treatment Goals and Objectives, Unknown Provider, 11/22/10, 01/28/11
- Chronic Pain Management Program Treatment Progress Report, 01/05/11, 01/13/11

- Procedure Note, Dr. 01/05/11
- Denial Letter, 02/03/11, 02/27/11
- Response to Denial Letter, 02/03/11
- RX History by Claim, 04/28/10 through 03/07/11
- The ODG Guidelines were not provided by the carrier or the URA.

PATIENT CLINICAL HISTORY (SUMMARY):

The patient slipped and fell while getting out of a truck on XX/XX/XX. He continued to experience problems and underwent surgery, a laminectomy and decompression discectomy of L4-L5, L5-S1 in April 2007. He received post-operative rehabilitation, aquatic therapy, time off, a back brace, medication, counseling and Epidural Steroid Injections (ESIs). His most recent medications were noted to be Hydrocodone, Flexeril, Vitamins B1, B6, B12, Soma, Ambien, Lyrica and hypertension medication provided by the emergency room.

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

Additional functional restoration five times a week over the next three to four weeks does not appear to be medically reasonable and necessary. The patient has completed an initial ten-day functional restoration program. The medical records reflect that the stated goals were to maximize the patient’s function prior to required surgery. This has not been addressed in the functional restoration program, nor is there any indication that the patient has met treatment goals in this regard. Criteria in the ODG for functional restoration programs indicates, “If the goal of treatment is to prevent or avoid controversial or optional surgery, a trial of ten visits (eight hours) may be implemented to assess whether surgery may be avoided.” As this has not been addressed, additional treatment is not medically reasonable or necessary. Additionally, criterion ten for continuation of treatment indicates, “Treatment is not suggested for longer than two weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gain.” This patient does not appear to have met the criteria for demonstrable objective gains, though subjectively he has improved. As such, further continuation of this program does not appear to be reasonable and necessary.

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)
- AMA GUIDES 5TH EDITION