



## Notice of Independent Review Decision

**DATE OF REVIEW:** 12/05/11

**IRO CASE #:**

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

Functional Restoration Program: 8 hrs x 10 days

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

Board Certified in Physical Medicine & 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: 8 hrs x 10 days – OVERTURNED

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

- Evaluation, Specialties, 07/30/09

- Disability Evaluation, M.D., 10/15/10
- Evaluation, Healthcare System, 04/01/10
- Examination Findings, Healthcare Systems, 05/03/11, 05/31/11, 07/12/11, 08/16/11
- Physical Performance Examination (PPE), Clinic, 08/29/11
- Evaluation, Healthcare Systems, 09/12/11
- Pre-Certification Request, Rehabilitation Center, 09/15/11
- Denial Letters, , 09/21/11, 10/26/11
- Request for an Appeal, Rehabilitation Center, 10/18/11
- The ODG Guidelines were not provided by the carrier or the URA.

**PATIENT CLINICAL HISTORY (SUMMARY):**

The patient was injured while on a scaffold performing xxxx. He fell from about six feet high and injured his back and right knee. He subsequently underwent two right knee surgeries in xxxx and 2000 and low back surgery in 2000. He has undergone several post-surgical diagnostic examinations and been treated with active and passive therapies, topical analgesics, injections, and medications. He was off work for two and one-half years. Previous medications have included Flexeril, Ibuprofen 800, Hydrocodone and Ambien. He continues to have severe pain levels and difficulty sleeping. He has mild levels of depression and anxiety. He is currently not working due to decreased functional ability, though he expresses a good attitude of wanting to return to work. He had been approved a work hardening program in the past, but was unable to participate due to his pain levels.

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

Based upon the provided documentation, the functional restoration program as proposed does appear to be medically reasonable and necessary per the Official Disability Guidelines. The patient has a chronic pain syndrome with loss of function, previous methods of treating this have been unsuccessful, thorough multidisciplinary evaluation has been made, there is documentation of motivation to change, etc. Therefore, it is my medical opinion that the patient sufficiently meets the appropriate criteria of the ODG.

Previous reviewers have indicated that as the patient has pathology older than 24 months (in this case twelve years), he is not a candidate, in part due to no documentation of the lower levels of care having been exhausted. I believe that this provision has been accomplished based upon the review of these records. Furthermore, while the prognosis is less clear in these individuals, programs with “documentation of success” can still be considered reasonable and necessary. As further indicated by the ODG, these 80 hours would be considered a trial period and significant functional gains would have to be demonstrated prior to considering additional treatment.

**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 5<sup>TH</sup> EDITION