

SENT VIA EMAIL OR FAX ON  
Mar/12/2011

## True Decisions Inc.

An Independent Review Organization  
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### NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:**

Mar/09/2011

**IRO CASE #:**

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

Functional Restoration Program x 10 days

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

Board Certified Anesthesiologist/Pain Management

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

OD Guidelines

1. Cover sheet and working documents
2. Letter dated 02/17/11
3. Response to denial letter dated 01/24/11
4. Functional restoration program patient treatment goals and objectives dated 01/14/11
5. Initial diagnostic interview dated 02/09/11, 01/14/11
6. Functional capacity evaluation dated 10/04/10
7. Procedure report dated 05/05/10
8. Medical records
9. Radiographic report dated 01/07/10
10. Physical therapy progress notes
11. Response letter dated 03/02/11
12. Utilization review determination dated 01/24/11, 02/18/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a female whose date of injury is XX/XX/XXXX. On this date the patient was involved in a motor vehicle accident. The patient is status post discectomy left L5-S1 on 03/31/05 and ACDF C4-5 and C5-6 with anterior plating on 06/12/09. Follow up note dated 03/23/10 indicates that the patient continues to complain of pain with associated numbness running from her cervical spine down to her lower lumbar area. The patient was recommended for epidural steroid injection and weight loss program. The patient underwent transforaminal epidural steroid injection at L5-S1 bilateral on 05/05/10.

Functional capacity evaluation dated 10/04/10 indicates that required PDL is light and current PDL is light. The patient has been recommended for additional surgery. Diagnostic interview update dated 01/14/11 indicates that the patient has completed 18 sessions of individual psychotherapy. BDI has improved from 20 to 14 and BAI from 28 to 20. Treatment to date is noted to include rest/off work, physical therapy, trigger point injections, massage, electrical stimulation, traction, epidural steroid injections, surgical intervention, individual psychotherapy and medication management. Medications are listed as Hydrocodone, Ibuprofen and Flexeril.

Initial request for functional restoration program x 10 was non-certified on 01/24/11 noting that documentation of exhaustion of recommended conservative treatment with objective documentation of patient response through VAS scales and physical therapy progress notes were not provided. The injury was more than XX months ago. The denial was upheld on appeal on 02/18/11 noting that there is no documentation of an absence of other options likely to result in significant clinical improvement.

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

Based on the clinical information provided, the request for functional restoration program x 10 days is not recommended as medically necessary, and the two previous denials are upheld. The patient has undergone extensive treatment for this injury to include rest/off work, physical therapy, trigger point injections, massage, electrical stimulation, traction, epidural steroid injections, surgical intervention, individual psychotherapy and medication management without significant improvement. There is no documentation that the patient is motivated to return to work. The patient's date of injury is greater than X years old, and the Official Disability Guidelines do not recommend functional restoration programs for patients whose date of injury is greater than 24 months old as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. Given the current clinical data, the requested functional restoration program is not indicated as medically necessary, and the two previous denials are upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION**

ACOEM-AMERICA 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)