

# Prime 400 LLC

An Independent Review Organization  
240 Commercial Street, Suite D  
Nevada City, CA 95959  
Phone: (530) 554-4970  
Fax: (530) 687-9015  
Email: manager@prime400.com

## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** May/06/2011

**IRO CASE #:**

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

Functional Restoration Program 80 hrs 97799

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

MD, Board Certified Physical Medicine and Rehabilitation and 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**

Official Disability Guidelines

Utilization review determination dated 03/14/11, 03/24/11

Appeal letter dated 04/13/11

Letter from patient undated

Reconsideration letter dated 03/16/11

Office visit note dated 03/04/11, 02/25/11

Functional capacity evaluation dated 03/04/11

Mental health evaluation dated 03/04/11

**PATIENT CLINICAL HISTORY SUMMARY**

The patient is a male whose date of injury is xx/xx/xxxx. On this date the patient was bent forward and a stone fell approximately 20 feet, hitting him in the back of the head. The patient has not worked since the date of injury. Mental health evaluation dated 03/04/11 indicates that the patient reports symptoms of anxiety and depression as well as sleep disturbance. BDI is 31. Diagnoses are pain disorder and major depressive disorder. Current medication includes Topamax. Functional capacity evaluation dated 03/04/11 indicates that required PDL is heavy and current PDL is sedentary.

Initial request for functional restoration program for 80 hours was non-certified on 03/14/11 noting there is no documentation of failed conservative management. No imaging studies were provided. Reconsideration letter dated 03/16/11 states that the patient has tried and failed multiple treatments and undergone extensive diagnostic testing. The denial was upheld on appeal dated 03/24/11 noting that the functional capacity evaluation had self-limited results due to observed inhibition. The patient has no job to return to. Official imaging reports were not provided. Due to the claimant's age, mostly unattainable goals and lack of documentation of failed conservative management, the request was denied.

**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 for 80 hours is not recommended as medically necessary, and the two previous denials are upheld. The submitted records fail to establish that the patient has exhausted lower levels of care and is an appropriate candidate for this tertiary level program. The patient has been diagnosed with major depressive disorder; however, there is no indication that the patient has undergone a course of individual psychotherapy. There are no imaging studies/radiographic reports provided.

The submitted functional capacity evaluation had self-limited results secondary to observed inhibition. The ODG criteria has not been satisfied based on the current clinical data. Functional Restoration Program 80hrs 97799 is not found to be medically necessary.

**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)