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IRO Certificate #4599

Notice of Independent Review Decision

DATE OF REVIEW: 6/20/13

IRO CASE NO.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Functional Restoration Program, 80 hours, CPT: 97799

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Physician Board Certified: Physical Medicine & Rehabilitation, Pain Management

REVIEW OUTCOME

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

Upheld	(Agree)	X
Overtured	(Disagree)	
Partially Overtured	(Agree in part/Disagree in part)	

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY SUMMARY

I have reviewed the medical information concerning patient, male, who was denied a request for a functional restoration program (80 hours). He is/was a worker, DOI: xx/xx/xx. The patient jumped over a fence, rolled his right ankle, and fell. MRI studies (xxxxx) showed evidence of some tearing of the posterior tibial tendon and partial tearing of the anterior talofibular ligament. A mild sprain of the deltoid complex was also noted. He underwent surgical treatment on 2/16/12, with several repair procedures. Patient states he attended post-op physical therapy, but continued having increased pain. A second surgery was performed on 11/29/12 with tenolysis and ligament reconstruction. In addition, he has had post-op home exercise program. Patient continues to be followed who referred him for FCE examination (5/16/13). Now there is a recommendation for 80 hours of a work conditioning period.

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

Decision:

I agree with the benefit company's decision to deny the requested service.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION (cont'd)

Rationale:

Reports state that the patient has already had 42 supervised rehabilitation sessions and has achieved significant improvement. There appears to be no adequate documentation indicating that a functional restoration program (80 hours) would make a significant difference. The patient has also recorded working out on his own/self rehabilitation. The conclusions stated on the 6/13/13 appeal response are particularly noted. I agree with those, and agree with the adverse determination.

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

ACOEM-AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL
MEDICINE UM KNOWLEDGE BASE

AHCPR-AGENCY FOR HEALTH CARE 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 & EXPERTISE IN ACCORDANCE WITH
ACCEPTED MEDICAL STANDARDS X**

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES X

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 DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES
(PROVIDE DESCRIPTION)