

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE NOTICE SENT TO ALL PARTIES:** Sep/14/2015

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** Functional restoration program  
80 hours

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** MD, Board Certified Family Medicine

**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 medical necessity exists for each health care service in dispute.** It is this reviewer's opinion that medical necessity for the request for functional restoration program 80 hours has not been established.

**PATIENT CLINICAL HISTORY [SUMMARY]:** The patient is a female who was injured on xx/xx/xx when she felt a pop in the right knee followed by pain. The patient was initially diagnosed with a high grade sprain of the ACL and MCL. Prior treatment had included physical therapy, aquatic based therapy, the use of a TENS unit, a walker, steroid injections, other medications, and individual psychotherapy. The functional capacity evaluation from 05/08/15 noted the patient was unable to perform even at a sedentary physical demand level. The patient was unable to perform her normal job at a light physical demand level. The 07/12/15 rep report noted that the patient had worsened over time. This was despite several medications for pain such as anti-inflammatories and narcotic analgesics as well as anticonvulsants. There was no indication that the patient had trialed psychotropic medications. The patient's FABQ scores were 22 for physical activity and 36 for work. The patient's BDI was 18 and BAI was 22. These results were decreased in comparison to previous scores. It was felt that primary and secondary levels of care had been exhausted. The appeal letter from 07/23/15 indicated patient was unable to proceed with surgical intervention for her claim as she was felt to be at maximum medical improvement. The patient was wishing to be able to return to work but could not due to her right knee pain.

The requested functional restoration program for 80 hours was first denied on 07/20/15 as surgery had been recommended for the patient and she was willing to undergo the surgery. The request was again denied on 08/21/15 for the same reason.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:** The patient has been followed for continuing complaints of right knee pain that has not improved with prior conservative treatment to include physical therapy, medications, or injections. There is an issue with the patient's surgical request based on the clinical records. The appeal letter indicated that the

patient would be unable to proceed with surgery as she was being placed at maximum medical improvement and surgery would not be covered under the Workers' Compensation claim. The patient had still not been able to return to work and continued to endorse both depression and anxiety symptoms as well as fear avoidance behaviors on the psychological assessments. The records; however, do not indicate failure of all lower levels of care. Based on the 07/12/15 assessment, the patient had improvements in both the BAI and BDI. It is there is also no indication the patient has failed prior conservative treatment to include the use of psychotropic medications. Given the lack of documentation regarding complete failure of lower levels of treatment, the requested functional restoration program would not be supported per guideline recommendations. Therefore, it is this reviewer's opinion that medical necessity for the request for functional restoration program 80 hours has not been established at this time and the prior denials remain 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)