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DATE NOTICE SENT TO ALL PARTIES: Jan/08/2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: functional restoration program x 10 days for left knee

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Internal 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 the opinion of the reviewer that the request for functional restoration program x 10 days for left knee is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male whose date of injury XX/XX/XX. The patient was driving a pallet jack when he fell out of the jack while his knee was stuck in the machine. The patient reported knee pain. Treatment to date includes MRI, physical therapy, activity modification, bracing, ACL repair on XX/XX/XX, x-rays, epidural steroid injections, massage and medication management. MRI of the left knee dated XX/XX/XX revealed postsurgical changes of ACL reconstruction with intact appearance of the graft. There is mild fraying of the inferior surface of the medial meniscus posterior horn with no discrete meniscal tear, collateral ligaments are intact. Functional capacity evaluation dated XX/XX/XX indicates that current PDL is medium and required PDL is medium. Treatment progress report dated XX/XX/XX indicates diagnoses are somatic symptom disorder with predominant pain, depressive disorder and anxiety disorder. The patient completed a course of individual psychotherapy. BDI decreased from 54 to 35 and BAI decreased from 45 to 40. Current medications are OTC arthritis medicine and Norco.

Initial request for functional restoration program x 10 days was non-certified on XX/XX/XX noting that this is a return to work program and the patient has returned to work. The prior job required a medium PDL and he is at a medium PDL. The psychological testing and pain levels strongly suggest exaggeration. The physical testing on the functional capacity evaluation has no validity measure and that is especially important given the psychological testing suggests exaggeration.

The patient can be weaned off hydrocodone without a functional restoration program. Response to denial letter dated XX/XX/XX indicates that an adequate evaluation has been made, methods of treatment to treat the pain condition have not been successful, there is a significant loss of ability to function independently resulting from the pain condition and there is a strong motivation to change. The denial was upheld on appeal dated XX/XX/XX noting that the claimant is XX years post injury, he is reported to have a medium level work capacity and is currently working. The records reflect somatization issues as well that would not be compatible with the program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries nearly XX years ago. The submitted records indicate that the patient has returned to work. There is no clear rationale provided to support a return to work program for a patient who has already returned to work. The patient's current physical demand level is medium which is also his required physical demand level. There is no documentation of psychometric testing with validity measures to assess the validity of the patient's subjective complaints despite Beck scales in a questionable range. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for functional restoration program x 10 days for left knee is not recommended as medically necessary and the prior 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 KNOWLEDGBASE

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)