



Specialty Independent Review Organization

Notice of Independent Review Decision

DATE OF REVIEW: 3/12/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a functional restoration program 5 x Wk x 2 Wks (80 hours of 97799).

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

The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a functional restoration program 5 x Wk x 2 Wks (80 hours of 97799).

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Records were received and reviewed from the following parties:
Coventry Healthcare WC and Dr.

These records consist of the following (duplicate records are only listed from one source): Records reviewed from Coventry Healthcare WC: Coventry Denial Letters – 2/2/12 & 2/17/12; International letter – 6/30/11; Functional Restoration Services of Texas IRO request for Functional restoration program – 2/20/12, Office Note – 1/27/12; Diagnostic MRI of the Left Hip w/o Contrast – 11/16/11; Neurological Assoc. Electroencephalogram report – 11/7/11, MRI Scan of the Cervical Spine w/o contrast – 11/11/11, MRI Scan of the Lumbar Spine w/o Contrast – 11/11/11, Electromyogram and Nerve Conduction Studies Report – 11/3/11; Imaging Centers MRI of the Left Hip – 11/14/11; and Radiology Assoc Cervical Spine Series – 10/5/11.

Records reviewed from Dr.: Visit Summary and Nurse Notes – 10/5/11-12/20/11, WC Health History – 10/5/11; and Various DWC73's.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient was injured on the job on xx/xx/xx. According to clinical records the worker slipped while descending stairs, missed a step, and fell down the remaining 9-10 steps to the ground, injuring her head, neck, hips and back. She was seen initially at an Emergency Department. On 10/05/2011 she was evaluated and treated by Dr., who diagnosed sprained neck (847.0), sprained hip and thigh (843.9), sprained lumbar region (847.2), and contusion of the face/scalp/neck (920). SLE was diagnosed as a comorbidity, with an annotation that the worker was already taking steroids and pain medication. Initial treatment included work restrictions, medication, physical therapy, a cervical collar and lumbar support. Subsequent medical care included neurology consultation, referral for an epidural steroid injection and referral for a functional restoration program.

On the follow-up visit on October 18, 2011, neck pain was reported to be a little better but severe occipital and frontal headaches occurred after treatment. The diagnosis of posttraumatic headache (339.20) was added.

On November 22, 2011, Dr. recommended follow-up with the worker's primary care physician regarding elevated blood pressure, follow-up with Dr., and referral to Dr. for consultation regarding neck and back pain with disc displacement.

On the follow-up visit December 20, 2011 the diagnosis of enthesopathy of the hip (726.5) was added. According to the clinical notes, Dr. had seen the worker and was awaiting approval for facet injections. The DWC form-73 certified that the worker was to remain off work.

Dr. referred the worker to Dr. for a functional restoration program, to determine if services were appropriate and if so to arrange for the services. At that time the medications were tramadol 50 milligrams four times daily, prednisone, Lortab 10/650: one or two every four hours, Prozac 20 milligrams daily, Ambien 12.5 milligrams at bedtime, and over the counter medications including Aleve, Advil and aspirin. Pain interfered with daily activities and interfered with sleep at night. The injured worker reported that she had started smoking cigarettes. Self-reported depression was documented, with BDI and BAI results in the moderate ranges. On 01/27/2012, enrollment in a functional restoration program was recommended, with goals as outlined, including individual and group therapy, physical therapy, and medication management.

The requested services were non-certified 02/02/2012.

On 02/20/2012 a request for reconsideration was submitted by Dr., the program director. Clinical information was again summarized, noting that the injured worker had participated in six sessions of individual counseling as well as 22

sessions of physical therapy, with progress that had plateaued. The worker was taking opiate medications and was interested in a full return to work. The worker was not a candidate for work hardening and therefore had been referred for the functional restoration program.

On reconsideration the requested services were again non-certified.

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

First, the injured worker has not had the opportunity to participate in a structured chronic pain management program. According to the ODG Integrated Treatment/Disability Duration Guidelines, Pain (Chronic), (updated 02/29/12):

In workers' compensation cases, providers may need to shift focus from a "cure and relieve" strategy to a "functional restoration" paradigm. Too much attention may be focused on the "pain" and not enough on functional restoration and gain that encourages "coping" strategies and the desirable outcome of "working" with pain. Also consider the possibility of patients developing "Wounded Worker Syndrome," a chronic pain condition characterized by failure of an injured worker to respond to conventional healthcare measures, and prolonged disability with continued absence from the workplace.

Second, the worker meets the criteria for a chronic pain management program; therefore the requested service is medically necessary. According to the ODG Guidelines Procedure Summary pertaining to chronic pain management, Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- **The patient has a chronic pain syndrome, with evidence of loss of function that persists beyond three months and has evidence of three or more of the following:** (a) Excessive dependence on health-care providers, spouse, or family; (b) Secondary physical deconditioning due to disuse and/or fear-avoidance of physical activity due to pain; (c) Withdrawal from social activities or normal contact with others, including work, recreation, or other social contacts; (d) Failure to restore preinjury function after a period of disability such that the physical capacity is insufficient to pursue work, family, or recreational needs; (e) Development of psychosocial sequelae that limits function or recovery after the initial incident, including anxiety, fear-avoidance, depression, sleep disorders, or nonorganic illness behaviors (with a reasonable probability to respond to treatment intervention); (f) The diagnosis is not primarily a personality disorder or psychological condition without a physical component; (g) There is evidence of continued use of prescription pain medications (particularly those that may result in tolerance, dependence or abuse) without evidence of improvement in pain or function.

- **Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.**
- **An adequate and thorough multidisciplinary evaluation has been made.** This should include pertinent validated diagnostic testing that addresses the following: (a) A physical exam that rules out conditions that require treatment prior to initiating the program. All diagnostic procedures necessary to rule out treatable pathology, including imaging studies and invasive injections (used for diagnosis), should be completed prior to considering a patient a candidate for a program. The exception is diagnostic procedures that were repeatedly requested and not authorized. Although the primary emphasis is on the work-related injury, underlying non-work related pathology that contributes to pain and decreased function may need to be addressed and treated by a primary care physician prior to or coincident to starting treatment; (b) Evidence of a screening evaluation should be provided when addiction is present or strongly suspected; (c) Psychological testing using a validated instrument to identify pertinent areas that need to be addressed in the program (including but not limited to mood disorder, sleep disorder, relationship dysfunction, distorted beliefs about pain and disability, coping skills and/or locus of control regarding pain and medical care) or diagnoses that would better be addressed using other treatment should be performed; (d) An evaluation of social and vocational issues that require assessment.
- If a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits (80 hours) may be implemented to assess whether surgery may be avoided.
- If a primary reason for treatment in the program is addressing possible substance use issues, an evaluation with an addiction clinician may be indicated upon entering the program to establish the most appropriate treatment approach (pain program vs. substance dependence program). This must address evaluation of drug abuse or diversion (and prescribing drugs in a non-therapeutic manner). In this particular case, once drug abuse or diversion issues are addressed, a 10-day trial may help to establish a diagnosis, and determine if the patient is not better suited for treatment in a substance dependence program. Addiction consultation can be incorporated into a pain program. If there is indication that substance dependence may be a problem, there should be evidence that the program has the capability to address this type of pathology prior to approval.
- **Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.**
- **There should be documentation that the patient has motivation to change, and is willing to change their medication regimen (including decreasing or actually weaning substances known for dependence). There should also be some documentation that the patient is aware**

- that successful treatment may change compensation and/or other secondary gains.** In questionable cases, an opportunity for a brief treatment trial may improve assessment of patient motivation and/or willingness to decrease habituating medications.
- **Negative predictors of success (as outlined above) should be identified**, and if present, the pre-program goals should indicate how these will be addressed.
 - If a program is planned for a patient that has been continuously disabled for greater than 24 months, the outcomes for the necessity of use should be clearly identified, as there is conflicting evidence that chronic pain programs provide return-to-work beyond this period. These other desirable types of outcomes include decreasing post-treatment care including medications, injections and surgery. This cautionary statement should not preclude patients off work for over two years from being admitted to a multidisciplinary pain management program with demonstrated positive outcomes in this population.
 - Treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. (Note: Patients may get worse before they get better. For example, objective gains may be moving joints that are stiff from lack of use, resulting in increased subjective pain.) However, it is also not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis.
 - Integrative summary reports that include treatment goals, compliance, progress assessment with objective measures and stage of treatment, must be made available upon request at least on a bi-weekly basis during the course of the treatment program.
 - Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). (Sanders, 2005) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).
 - At the conclusion and subsequently, neither re-enrollment in repetition of the same or similar rehabilitation program (e.g. work hardening, work conditioning, out-patient medical rehabilitation) is medically warranted for the same condition or injury (with possible exception for a medically necessary organized detox program). Prior to entry into a program the evaluation should clearly indicate the necessity for the type of program required, and providers should determine upfront which program their patients would benefit more from. A chronic pain program should not be considered a “stepping stone” after less intensive programs, but prior

participation in a work conditioning or work hardening program does not preclude an opportunity for entering a chronic pain program if otherwise indicated.

- Suggestions for treatment post-program should be well documented and provided to the referral physician. The patient may require time-limited, less intensive post-treatment with the program itself. Defined goals for these interventions and planned duration should be specified.

Post-treatment medication management is particularly important. Patients that have been identified as having substance abuse issues generally require some sort of continued addiction follow-up to avoid relapse.

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

- ACOEM- AMERICAN 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)