

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: November 24, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

1 Additional 80 Hours of Functional Restoration Program for symptoms related to the Left Ankle/Foot Injury, as Outpatient

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

This physician a Board Certified Orthopedic Surgeon with over 40 years of experience.

REVIEW OUTCOME:

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

Overturned (Disagree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

07/16/13: Evaluation
07/16/13: Initial Evaluation- PT
07/30/13: Evaluation
07/30/13: Quantitative Functional Capacity Evaluation
07/30/13: Mental Health Evaluation
08/21/13: Evaluation
09/11/13: Evaluation
09/16/13: Progress/Staffing Note
09/17/13: Quantitative Functional Capacity Evaluation
09/24/13: UR performed
09/26/13: Evaluation
10/02/13: Reconsideration Letter
10/??/13: Letter

10/14/13: UR performed
10/16/13: Evaluation
10/16/13: UR Addendum
10/17/13: Evaluation

PATIENT CLINICAL HISTORY [SUMMARY]:

This claimant is a male who was injured on xx/xx/xx when he “rolled” his, feeling a “snap” and fell to the ground. He was initially seen and was placed in an air boot and put on crutches. He had 2 lumbar sympathetic blocks for suspected sympathetically-mediated pain in 11/2012 and 12/2012. The injections were temporarily helpful. An MRI was performed in 10/2012, no records available. An EMG was also done in 10/2012 which suggested CRPS type 2. It was reported he had 2 months of 3-times-per-week reconditioning therapy with little improvement.

On July 16, 2013, the claimant was evaluated for complaints of compensable left ankle/foot pain and non-compensable injury-related and disputed nonradiating low back pain. The claimant complained of hypersensitivity on the top of the foot and ankle with swelling that was variable but occasionally “massive” with “purplish” color change intermittently and “ice cold” temperature change intermittently. He also reported a severe antalgic gait because he “can only bear weight on my heel.” His pain intensity was reported as 10/10 and made worse by virtually all activities involving ambulation and standing. It was reported he spends 22 hours sleeping/reclining. On physical examination he had some areas of extreme hypersensitivity with a pattern of neuropathic pain that extended out over the metatarsals both dorsally and on the plantar surface of the foot but not including the toes themselves. The extreme hypersensitivity with some erythema extended proximally along the lateral aspect of the foot to the area of the calcaneus, whereas it only included the metatarsals on the medial side of the foot. Similarly, on the plantar side, the arch and heel were not particularly tender with the heel having a major callus present. There was some coolness and temperature change going one-third of the way up the lower leg more laterally than medially, which was also mildly hypersensitive with essentially normal appearance and sensation proximal to that. His gait was grossly abnormal without a cane, essentially “hopping” off his heel with an extremely short stance phase. Even with use of his cane, he had a grossly abnormal gait. Diagnostic Impression: 1. Chronic left foot/ankle sprain/strain with current physical exam findings of a severe neuropathic pain including distal foot hypersensitivity with some temperature/color change and loss of ankle mobility with grossly abnormal gait, partially responsive to prior lumbar sympathetic blocks. Recommendations: Request PT/OT/Disability Assessment with lower extremity Functional Capacity Evaluation and Mental Health Evaluation and return to discuss treatment.

On July 30, 2013, the claimant was re-evaluated who reported that on his physical testing, he had a long list of ADLs that he had difficulty with. He had moderate foot/ankle mobility and extreme strength deficits associated with a nonfunctional gait relative to his job demands. His strength performance suggested some level of psychological Fear-Avoidance complicating the physical deficits. His truck driving job requirements for material handling was in the Very Heavy PDL and his current PDL was found to be Below Sedentary. He also failed to meet positional

demands for balancing, sitting, squatting, standing, walking, climbing, and twisting. On his Mental Health Evaluation, they identified severe loss of function (GAF of 46) with moderate stressors (PSS of 3). He had a severe level of depressive symptoms (BDI of 25, IDS of 36). He had other psychosocial issues of concern that included anxiety/agitation, thought processes disrupted, sleep disturbance, narcotic, muscle relaxants, tranquilizers or seductive-hypnotic medications currently used, maladaptive illness and disability beliefs, behaviors related to pain, fear, and/or avoidance possibility undermining therapeutic environment, family dysfunction or discord increased secondary to injury-related stresses. Plan: The claimant met all ODG criteria for an opportunity to participate in an initial 80 hours of a Functional Restoration program.

On August 21, 2013, the claimant was re-evaluated for continued left ankle and foot pain. It was noted he had started his Functional Restoration program. It was also noted he was on Hydrocodone 7.5 mg and that they would begin tapering that medication the following week. He would be using ibuprofen as a NSAID and Lunesta 3 mg at bedtime p.r.n. and also Lexapro 10 mg increasing to 20 mg in the next 2 weeks.

On September 11, 2013, the claimant was re-evaluated who reported he was making good progress in the Functional Restoration program and in his weight bearing. He was still utilizing his cane, but mostly for balance while "equalizing" his gait with short steps and equal stance phase. On physical examination his gait showed a very short stance phase but was equal in terms of amount of time on full weight bearing and he showed the ability to do some heel walking bilaterally. He ambulated without a cane. His left ankle and foot continued to show tenderness with mobility deficits but had improved plantar flexion and dorsiflexion. He also had improved strength on eversion.

On September 16, 2013, Progress Notes indicated that the claimant had demonstrated compliance with the program. Current Pain Level Range was now documented to be 7-9 and it was noted that he was significantly more physically active and experiencing fewer flare-ups. He was no longer ceasing physical activity when a flare-up with pain happened, but was instead learning pain management strategies and techniques to decrease the length, severity, and frequency of flare-ups. Starting medications were listed as Tramadol 80 mg and Tylenol, current medications were Lexapro 20 mg, Hydrocodone 7.5 mg, Lunesta 3 mg, and ibuprofen 800. Psychology: GAP increased from 46 to 52. Symptoms of depression had decreased from a severe level to a moderate level and symptoms of anxiety had decreased from a moderate level to a mild level. Reconditioning and Functional Activities: Based on mid-program testing, he progressing in: Bending from never to occasional, PDL from below Sedentary to Light/Medium, Completing full gym with fatigue, occasional standing to frequent standing but not prolonged, and increase in left ankle ROM.

On September 24, 2013, performed a UR. Rationale for Denial: Although the doctor stated that EMG described reflex sympathetic dystrophy, there really is no evidence of CRPs. There is no atrophy of the muscle, there is no bone scan to

show disuse dystrophy. The subjective diagnosis of feeling cold and intermittent purplish color is difficult to verify. There is a pain intensity of 9/10, one year after the injury with 80 hours of restoration therapy already performed. There is no support for an additional 80 hours and has 9/10 pain.

On September 26, 2013, the claimant was evaluated who prescribed the following medications: Lyrica titrate to 150 mg, Dibenzline 10 mg every other day for a week and then daily, Effexor CR 75 mg and then 150 mg x1week and then 225mg, katemine 5%/Catapre 0.2% gel, Lunesta 3 mg at bedtime p.r.n. only, Hydrocodone 7.5 mg. (rare occasions).

On October 2, 2013, wrote a Reconsideration Letter in which he made it clear that the Functional Restoration Program was already approved and this was a Concurrent Review. stated that when looking at the full picture that the claimant had been making excellent progress physically in terms of his gait, his training level and even with his pain. He made the point that ODG specifically has criterion #10 in which it states that a Concurrent Review should not be inappropriately delayed, as felt it was in this case. He reported that the claimant began with pain at rest at 10/10 and his pain at rest now was down to 7/10. Specific reasons given why continuation of the program should be approved were: 1. The claimant was making excellent progress as shown by the CCR form. 2. The claimant has documented functional improvement in terms of gait, going from total dependence on a cane to walking in the gyms without a cane and extending the distance of walking without a cane with improved stride length and decrease in antalgic gait with greater tolerance of weight bearing that is the major factor documenting improvement in a situation of neuropathic pain; 3. Severe depression had improved to the moderate range (BDI down from 29 to 20); 4. Marked improvement in the claimant's materials handling capability going from below Sedentary at the start of treatment to now a much improved Light/Medium PDL, but still needing substantial improvement to original job requirements in the Very Heavy PDL.

On October 14, 2013, performed a UR. Rationale for Denial: Based on the clinical information presented for review, there is no clear clinical indication for an additional 80 hours of functional restoration protocols. There's been no objectified improvement in the overall situation. Therefore, the efficacy of such intervention is not supported. As noted in the ODG, these types of protocols are recommended for selected patients and given there has not been no improvement, the request is not medically necessary.

On October 17, 2013, the claimant was re-evaluated who noted on physical examination he ambulated with mild antalgia on his left leg due to his left ankle/foot pain. There remained mild swelling in the left ankle with mobility deficits and some improved but present hypersensitivity. Neurovascular exam was otherwise intact. reported the claimant had no completely discontinued his Hydrocodone. He was changed to Nueynta 75 mg 4 times a day because of its neuropathic pain benefits. Dibenzylamine was increased from 10 mg up to 30 mg. He had discontinued Lyrica and Lexapro and would be trying Pristiq 50 mg.

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

The previous adverse determinations are overturned. The claimant is showing significant signs of improvement with the functional restoration program. ODG criteria #10 states that “treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains”. According to the program progress notes on September 16, 2013, the claimant had demonstrated compliance with the program. Subjectively, his pain level range now documented to be 7-9, down from 9-1. It was noted that he was significantly more physically active and experienced fewer flare-ups. He was no longer ceasing physical activity when a flare-up with pain happened, but was instead learning pain management strategies and techniques to decrease the length, severity, and frequency of flare-ups. also reported on October 2, 2013 that the claimant had documented functional improvement in terms of gait, going from total dependence on a cane to walking in the gyms without a cane and extending the distance of walking without a cane with improved stride length and decrease in antalgic gait with greater tolerance of weight bearing. He also had marked improvement in materials handling capability going from below Sedentary at the start of treatment to a much improved Light/Medium PDL. The request for 1 Additional 80 Hours of Functional Restoration Program for symptoms related to the Left Ankle/Foot Injury, as Outpatient meets ODG criteria and is found to be medically necessary.

PER ODG:

Functional restoration programs (FRPs)

Recommended for selected patients with chronic disabling pain, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Functional restoration programs (FRPs), a type of treatment included in the category of interdisciplinary pain programs (see [Chronic pain programs](#)), were originally developed by Mayer and Gatchel. FRPs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. These programs emphasize the importance of function over the elimination of pain. FRPs incorporate components of exercise progression with disability management and psychosocial intervention. Long-term evidence suggests that the benefit of these programs diminishes over time, but still remains positive when compared to cohorts that did not receive an intensive program. ([Bendix, 1998](#)) A Cochrane review suggests that there is strong evidence that intensive multidisciplinary rehabilitation with functional restoration reduces pain and improves function of patients with low back pain. The evidence is contradictory when evaluating the programs in terms of vocational outcomes. ([Guzman 2001](#)) It must be noted that all studies used for the Cochrane review excluded individuals with extensive radiculopathy, and several of the studies excluded patients who were receiving a pension, limiting the generalizability of the above results. Studies published after the Cochrane review also indicate that intensive programs show greater effectiveness, in particular in terms of return to work, than less intensive treatment. ([Airaksinen, 2006](#)) There appears to be little scientific evidence for the effectiveness of multidisciplinary biopsychosocial rehabilitation compared with other rehabilitation facilities for neck and shoulder pain, as opposed to low back pain and generalized pain syndromes. ([Karjalainen,](#)

2003) Treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. For general information see [Chronic pain programs](#).

Criteria for the general use of multidisciplinary pain management programs:

Outpatient pain rehabilitation programs may be considered medically necessary in the following circumstances:

- (1) 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.
- (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement.
- (3) 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.
- (4) 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.
- (5) 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.
- (6) Once the evaluation is completed, a treatment plan should be presented with specifics for treatment of identified problems, and outcomes that will be followed.
- (7) 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.
- (8) Negative predictors of success (as outlined above) should be identified, and if present, the pre-program goals should indicate how these will be addressed.
- (9) 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.

(10) 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.

(11) 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.

(12) 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).

(13) 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.

(14) 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.

(15) 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.

Inpatient pain rehabilitation programs: These programs typically consist of more intensive functional rehabilitation and medical care than their outpatient counterparts. They may be appropriate for patients who: (1) don't have the minimal functional capacity to participate effectively in an outpatient program; (2) have medical conditions that require more intensive oversight; (3) are receiving large amounts of medications necessitating medication weaning or detoxification; or (4) have complex medical or psychological diagnosis that benefit from more intensive observation and/or additional consultation during the rehabilitation process. ([Keel, 1998](#)) ([Kool, 2005](#)) ([Buchner, 2006](#)) ([Kool, 2007](#)) As with outpatient pain rehabilitation programs, the most effective programs combine intensive, daily biopsychosocial rehabilitation with a functional restoration approach. If a primary focus is drug treatment, the initial evaluation should attempt to identify the most appropriate treatment plan (a drug treatment /detoxification approach vs. a multidisciplinary/interdisciplinary treatment program). See [Chronic pain programs, opioids](#); [Functional restoration programs](#).

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 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)**