

# Health Decisions, Inc.

6601 CR 1022  
Joshua, TX 76058  
P 972-800-0641  
F 888-349-9735

## Notice of Independent Review Decision

August 17, 2015

### IRO CASE #:

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:** 97799 FR-CA Functional Restoration Program-80 hours/units- outpatient

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:** American Board Certified Physician of Physical Medicine & Rehabilitation with over 16 years' experience.

### REVIEW OUTCOME:

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

Upheld (Agree)

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

### PATIENT CLINICAL HISTORY [SUMMARY]:

This authorization request for 80 hours of Functional Restoration Program. The Client worked as a x for x. It was reported that on September 7, 2013 the client was burning trash when water from on top of the bag leaked out and burned his left foot. The client was taken to Baylor ER where he received treatment and continued care at NOVA. The client decided to choose his own treating doctor, and he's now under medical supervision. He was examined and therapy was prescribed. The client had one round of therapy with no improvement. Pt still complains of sharp burning pain in the left foot. Pt suffered from nerve pain so was sent to a foot specialist. Pt was seen after he was diagnosed with RSD for injection in the ankle but not the foot. completed injections in his back, which the patient found helpful but stated that is was wearing off. indicated the results of his injections were positive and has recommended a Spinal cord stimulator. He had a permanent SCS placed on 12/23 which reduced the pain significantly. Presently, the patient continues to report marked pain and unresolved functional problems that are associated with reliance on significant others to complete ADL's and unemployment. His treating doctor has recommended participation in an interdisciplinary Functional Restoration Program.

05/27/15: Texas Medical Institute (TMI) Physical Performance Evaluation: Patient has been diagnosed with: 337.20 (UNSO RFLX SYMPH DYSTRPH), 945.22 (2<sup>nd</sup> DEG BURN FOOT) And reports sharp burning pain in the left foot. Past medical history: HTN Assessment: The pt has made objective improvements in the following area since last evaluation: Dynamic lifting. The pt has made objective improvements in the following area since last evaluation: Static Strength. The pt cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes. Based on the findings, the pt may benefit from a referral to a functional restoration program. According to objective findings from testing including: PILE lifting, static

lifting, the clinical examination, and all other activities previously mentioned in this report; it is my opinion that this pt does not meet the requirements, safety, and performance ability to do their job safely, effectively, and confidently (without restrictions). The pt is not capable of performing their job duties (without restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.

06/24/15: TMI Physical Performance Evaluation: No changes from last assessment dated 05/27/15.

06/29/15: Reassessment for Functional Restoration Program: Patient appeared appropriate for age and casually dressed. Pt was wearing a special shoe on the left foot. Pt was cooperative and oriented. Psychomotor activity was abnormal Pt is using a cane to walk. His mood is somewhat dysphoric, his affect was mildly constricted. We concur with recommendation that the patient continue to participate in a Functional Restoration Program as Mr. McGraw has exhausted conservative treatment, has made progress, yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. Thus, it is recommended that he be approved for continued participation in the Functional Restoration Program in order to maintain his progress, increase his physical and functional tolerances and to facilitate a safe and successful return to work.

07/01/15: Request for 80 additional hours of a Functional Restoration Program: Clearly, the program has exerted a positive impact on the patient's symptoms; however, he has not met the targeted reduction of 75% in every active symptom. He requires an additional 80 hours of interdisciplinary functional restoration program in order to extinguish active symptoms over a long term basis, maximize his functional tolerances and propel him toward a safe return to work. The pt has been informed by his surgeon, he cannot return to work at the airport due to interference to the waves from his SCS. He wants to return to school. has evaluated him and noted that he is an appropriate candidate for progression to a functional restoration program. Based upon the records, information gathered across assessment periods, and limited response to low- level treatment, Pt is a suitable candidate for a tertiary level of care. Pt presenting problems are consistent with a diagnosis of chronic pain. Thus, authorization for 80 additional hours in a Functional Restoration Program appears reasonable and medically necessary for any lasting management of his pain symptoms and is the recommended treatment for chronic pain syndrome.

07/08/15: UR: Rationale: The opinions set forth by the requesting provider are very much respected. However, for the described medical situation the above noted reference (ODG pain chapter) would not support this specific request to be one of medical necessity. Previous treatment has included 160 hours of functional restoration program. The above noted reference would typically support an expectation that maximal benefit from such an extensive program would be obtained after this amount of treatment is a functional restoration program is provided to an individual. This request would exceed what would be supported per criteria set forth by the about noted reference. As a result, presently, medical necessity for this request is not established.

07/20/15: UR: Upon review, it was determined that this request still does not meet medical necessity guidelines. Recommend adverse determination. The claimant has been afforded a full course of treatment in a chronic pain management program. ODG guidelines stats that treatment in excess of 160 hours requires a clear rationale for the extension as well as the provision of reasonable goals to be achieved. A clear rational as to why this individual would require additional treatment beyond the ODG maximum is not provided. Specific reasonable and achievable goals are similarly not outlined. Medical necessity for 80 additional hours of a chronic pain program in excess of OGD recommendations is not established.

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

Determination: denial of an additional 80 hours of functional restoration program is UPHELD/AGREED UPON since request exceeds ODG recommended number of hours for submitted diagnosis, and clinically, after completion of 160 hours of functional restoration there is documentation of no changes in function from the 5/27/15 to 6/24/15 Physical Performance Evaluations. Furthermore, there is no documentation of improvement in psychometric testing, there is no

documentation regarding medication use and change in such, and there are no specific goals outlined in any of these areas (function, psychosocial state, medications), nor vocational planning. Therefore an additional 80 hours of functional restoration program is not medically necessary.

**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 4 weeks (20 full-days or 160 hours), or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities. ([Sanders, 2005](#)) If treatment duration in excess of 4 weeks is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided. 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)**