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DATE: May 21, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional Restoration Program 80 units 97799

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

The reviewer is certified by the American Board of Anesthesiology with over 6 years of experience.

REVIEW OUTCOME:

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

The claimant is a female who was injured after falling down stairs while working on xx/xx/xx.

05/09/14: The claimant was evaluated (hand-written signature not legible). It was noted that she fell down stairs at work. She had lumbar pain and swelling and pain in the left knee and lower extremity. She stated that her knee gave out. On exam, she had edema in the left knee with negative drawer sign. She had lumbar paraspinal spasm. Assessment was left knee sprain/meniscal tear, lumbar strain/spasms/HNP, and pedal edema. The plan was for an MRI left knee/lumbar, compression hose, needs PT and/or continue.

05/27/14: MRI Lumbar Spine report. IMPRESSION: Posterior annular disc bulge at L3-L4. Broad-based disc bulge at L4-L5 with abutment of both L5 nerve roots in the lateral recesses. Broad-based disc bulge with annular tearing at L5-S1.

05/27/14: MRI Left Knee report. IMPRESSION: Large knee joint effusion. Mild diffuse cartilage thinning in the patellofemoral joint.

07/08/14: The claimant was evaluated for lumbar pain, left kneed pain, and left elbow pain. The plan was for soft tissue injection with 1 mg of Depo-Medrol and 1 mL of 1% lidocaine into all three areas, 1 mL of lidocaine and 1 mg of Depo-Medrol into the right buttocks over the sacrum, physical therapy, rehab, and heat to the low back at injected spots, and knee and elbow injections in 1 month.

09/17/14: The claimant was evaluated for back and leg pain rated 8/10. She was noted to be taking opiates and had attended physical therapy with temporary benefit. Trigger point injections gave temporary benefit as well. Her medications included Effexor XR, Neurontin, Norco 10/325 mg, and Zanaflex 4 mg. On exam, her gait was antalgic. She had moderate muscle spasm and paraspinous tenderness in the lumbar spine. She had painful palpation in the bilateral greater trochanters, buttocks, and SI joints. Patrick's and FABER were positive bilaterally. SLR was positive bilaterally. She had decreased active range of motion with lifting factors of pain in the lumbar spine. Assessment was lumbar sprain or strain, radiculitis, displacement of lumbar intervertebral disc, myalgia and myositis, sacroiliitis, and other bursitis disorders. The plan was for transforaminal lumbar epidural steroid injection.

09/25/14: The claimant was evaluated who injected the left elbow and left lateral epicondyle with 0.5 mg of Depo-Medrol and one-half cc of 1% lidocaine. The left knee was injected with 2 mg of Depo-Medrol, both 40 mg/cc, and one and one half cc of 1% lidocaine. She was to place heat on those areas and have physical therapy. She was to continue on her current medications.

10/09/14: The claimant was evaluated. She reported a pain score of 7. She reported having aching pain on her left shoulder, pins and needle like pain running down her left arm, and pins and needle like pain on her left elbow. She reported pins and needle pain and stabbing pain on both of her hips. She reported having numbness and stabbing pain on her lower back. She reported numbness on her left knee and aching on her left thigh. On the McGill Pain Questionnaire, she scored a 73, indicating severe-debilitating pain. Her pain consisted of pounding, shooting, piercing, penetrating, tearing, suffocating, and torturing. She described her continuous pain as horrible. On the Pain Experience Scale, she scored 91.5, indicating that she was experiencing severe-extreme levels of depression consisting of very often feeling frustrated, depressed because of her pain, feeling overwhelmed, and thinking it was too hard to do anything when she had her pain. She reported very often being worried if her pain would get worse, worried about her family, and wondered how long her pain would last. On the Beck Depression Inventory, she scored 30, indicating severe-extreme levels of depression consisting of issues pertaining to pessimism, dissatisfaction, insomnia, loss of libido, and weight loss. On the Beck Anxiety Inventory, she scored 46, indicating a severe level of anxiety. On the Sleep Questionnaire, she scored 45, indicating mild levels of sleep problems. On the FABQ, she scored 22 in the Physical Sub Scale and a 42 in the Work Sub Scale, cumulating to a 66, suggesting elevated levels of avoidance and fear related to work-related injury and impact of her pain on her current level of physical functioning. On the Revised Oswestry Low Back Pain Disability Questionnaire, she scored 70% disabled, indicating severe level of

disability. The diagnostic impression was pain disorder associated with both psychological factors and a general medical condition, depressive disorder related to injury medical condition, anxiety disorder related to injury medical condition, and occupational problems. Individual psychotherapy was recommended.

10/09/14: The claimant underwent transforaminal lumbar epidural steroid injection at L4-L5 and L5-S1.

10/10/14: The claimant was evaluated. It was noted that she underwent ESI the day prior without relief. She was given refills of Norco and Zanaflex and was to continue with physical therapy and injections.

10/29/14: The claimant was evaluated. She noted significant benefit in the low back for only 2 days. She had noted a 50% benefit in the leg pain and continued to appreciate that benefit. She particularly noted that the shooting pain was gone. She was having increasing spasms in the low back. She had participated in physical therapy for 2 weeks. She was to be scheduled for medial branch block.

12/04/14: The claimant was evaluated. She was assigned a Whole Person Impairment of 5%. The clinical date of Maximum Medical Improvement was September 25, 2014.

12/31/14: The claimant was evaluated for alternate MMI and impairment rating. The impression was lumbar sprain and strain, left knee strain, left elbow strain, and disc bulge with annular tearing at L5-S1. It was determined that she had not reached MMI; the lumbar sprain and strain and left knee sprain and strain had been treated adequately with physical therapy. It was suggested that she have viscosupplementation injections into the left knee to alleviate the traumatic inflammatory condition that existed in the knee at the time of this visit. It was also noted that she would need physical therapy directed to the left elbow. recommended a 2nd epidural steroid injection to the low back. Impairment rating was not given as she had not reached MMI.

02/24/15: The claimant was evaluated who noted that she was overall functioning in the sedentary category of work. It was recommended that she continue lumbar spine/left knee treatment protocol as suggested by ODG to improve her body mechanics, increase overall endurance, strength, range of motion, and decrease pain and pain medication. It was noted that she would benefit from a multidisciplinary program such as a chronic pain management program to decrease pain and pain medication and increase awareness of coping skills.

03/06/15: The claimant was evaluated. FABQ score 20 (decrease of 2 points) on physical sub scale and 33 (decrease of 9 points) on the work sub scale. Patient Pain Drawing rating of 6-7. Pain Experience Scale score of 68.5, moderate pain (decrease of 23 points). Revised Oswestry Low Back Pain Disability Questionnaire score of 65%, indicating crippling perception level of disability. DASH score of 55% (decrease of 12.5%), severe. Pain Disability Questionnaire score of 54/90 on the Functional Status Component, 44/60 on the Psychosocial

Status Component, and Total PDQ score 143/150. McGill Pain Questionnaire score of 70 (severe-debilitating), a 3-point decrease from previous score of 73. Sleep Questionnaire score of 31 (decrease of 14 points from prior score of 45). Beck Anxiety Inventory score of 35 (decrease of 11 points). Beck Depression Inventory score of 21 (decrease of 9 points). Based on the outcome of individual counseling and the functional capacity evaluation, it is this examiner's standpoint that the claimant would highly benefit from a multidisciplinary program. She will have the opportunity to receive physical, medical, and mental health treatment along with the appropriate case management assistance. Goals: Decrease Beck Depression Inventory by 6 points, decrease Beck Anxiety inventory by 6 points, continue to decrease Sleep Questionnaire by 7 points, assist in improving functional restoration by reduction on the Pain Experience Scale by 10 points, and reduce reported pain levels by 3 points, as well as reduction in both subscales of the FABQ-R by 4 points, assist in developing an appropriate vocational plan/stress, continue to monitor her narcotic extinction protocol and medication management plan for patient in order to address concerns related to medications, and assist in developing an appropriate weight reduction/nutritional management.

03/12/15: UR. RATIONALE: Review of treatment course indicates that the patient has had a long course of debilitating pain in many regions. Etiology of pain was due to multiple pain generators in limbs and axial back pain, with significant psychiatric exacerbation and pain syndrome. Goals of functional restoration program (FRP) not well delineated in review request. Therefore, this request is not medically necessary.

03/24/15: The claimant was evaluated, FNP for complaint of ongoing low back pain. She reported that her pain in her low back had worsened in the interval of her last visit. She stated that it was constant and 8/10. She complained of ongoing popping, locking, swelling, instability, weakness, and night pain. It was generally worsened with weather changes and was mitigated with rest. On exam, she had a slow and antalgic gait. Negative foot drop, drag, or slap. She ambulated with the assistance of a single point cane. Negative bracing. Paraspinal muscle pain was present with palpation from L3 through S1, left greater than right, radiating into the left gluteal muscle. Range of motion was decreased in all fields with pain reported at terminal end of flexion, extension, and left rotation. Somewhat guarded posture. Assessment was lumbar spine sprain-strain and left knee sprain-strain. Under the plan, noted that "the patient has not been evaluated in this clinic since 12/30/14. She is scheduled to be evaluated by spine surgeon, later in the week." planned to follow up with her regarding update of status and progression of care and to range for her previous imaging studies to be delivered to his office. She was to continue with her medications and physical therapy.

05/01/15: UR. RATIONALE: In spite of the designated doctor's findings, the patient feels her medical problem is extremely severe and extremely permanent if untreated. Multiple questionnaires given to the patient show severe pain, disability, anxiety, and depression. The patient takes opioids daily and the dosage prescribed suggests habituation is likely. Looking at the ODG criteria for

a chronic pain management program, the patient does not meet criterion #1, as there is no significant evidence of loss of function. Criterion #2 is true. Criterion No. 3 appears true, but it cannot be determined how strength was measured and validation of these measurements is absent. There are no coefficients of variation or time/force curves. Criteria #4 and #5 are inapplicable. Criterion #6 is true. Criterion #7 (documentation that the patient has motivation to change and is willing to change their medication regime) is not true. This has not been documented, and there may be an issue in this area. The available clinical information does not support that the request is medically reasonable and necessary. The medical necessity of this request is not certified. This conclusion is consistent with Official Disability Guidelines (chapter on pain).

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

The previous adverse decisions are upheld. Claimant does not meet many of the criteria outlined by ODG to justify a chronic pain management program. Claimant does not demonstrate loss of function. There is no explanation how strength was measured and if those measurements were validated. There is no documentation that the patient has motivation to change and is willing to change their medication regime. The available clinical information does not support that the request is medically reasonable and necessary. Therefore the medical necessity of this request for Functional Restoration Program 80 units 97799 is not certified.

ODG:

<p>Chronic pain programs (functional restoration programs)</p>	<p>Criteria for the general use of multidisciplinary pain management programs: <u>Outpatient</u> 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.</p>
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	<p>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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(9) If a program is planned for a patient that has been continuously disabled</p>
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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.

	<p><u>Inpatient</u> 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.</p>
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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)**