



**MEDICAL EVALUATORS
OF T E X A S ASO, LLC.**

2211 West 34th St. • Houston, TX 77018
800-845-8982 FAX: 713-583-5943

DATE OF REVIEW: October 29, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Denial of coverage for Functional Restoration Program (80 hours)

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

This case was reviewed by a board certified Psychologist who is currently licensed and practicing in the state of Texas.

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)

EMPLOYEE CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on XX/XX/XX felt a pop in the right knee when he was standing up. Prior to this injury, the claimant was experiencing depression due to his work injury on XX/XX/XX when he was. Previous treatment included medication management, physical therapy, steroid injections, and work hardening program.

An office visit dated xxxxx indicates the claimant had been through a course of physical therapy focusing on quad strengthening and patellofemoral rehabilitation without improvement. The claimant also already had a corticosteroid injection intra-articularly which did not appreciably improve his symptoms. On exam, the right knee exam showed no swelling, ecchymosis or deformity. There was mild patellar crepitus, mild medial and lateral patellar facet tenderness and no evidence of effusion. Full range of motion in all areas tests. Strength was 5/5 in all muscle groups. Sensation was intact. Positive for patellar ballottement and entrapment testing. McMurray's Anterior Drawer, Posterior Drawer, Apley's Lachman's and Valgus Stress tests were all negative. Gait patterns was normal with no limp. The assessment was right knee chondromalacia patella.

Functionl capacity evaluation dated xxxxx revealed: Based upon the physical assessment and work demand as outlined, is not capable of physically performing all of his pre-injury work demands. In general work physical demand levels (PDL) are in the



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Medium PDL (up to 75 lbs). His present functional abilities are in the less than Sedentary to Light PDL (0 to 20 lbs).

On xxxxx, the claimant had mental health testing at, MS, xxxxx and was determined that based on claimant's current affective and mood symptoms and continued pain, the claimant would highly benefit from a multidisciplinary program such as functional restoration program.

An initial denial letter dated xxxxx indicates the ODG indicates that the criteria for participating in a functional restoration program includes that previous methods of treating pain have been unsuccessful and there is an absence of other options likely to result in clinical improvement. However, the injured employee has persistent knee pain and there is a meniscal tear identified on MRI. It is unclear why surgery has not been pursued as there has been lack of improvement with conservative treatment. Considering these objective MRI findings, continued symptoms, and the guideline recommendations, this request for participation in a functional restoration program is not medically necessary.

A second denial letter dated xxxxx indicates based on the documentation provided the injured worker does not meet the criteria for functional restoration program as per ODG. Specifically, under exterior #1, if the diagnoses cannot primarily be a personality disorder or psychological disorder without a physical component. The physical component is minimal in this. The injured worker has been diagnosed with a knee sprain. There is evidence of underlying degenerative changes that preexist the documented injury. From the documentation provided, the documents clearly indicate that the current limitations are related to the ongoing psychiatric complaints with only moderate to minimal dysfunction of the knee and the lack of any substantial underlying pathology that would be treated surgically. As such, the request is considered not medically necessary and is recommended for non-certification.

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

The ODG supports the use of functional restoration program after development of psychosocial sequelae that limits function or recovery after the incident. According to the review of submitted medical records, this claimant sustained right knee injury on xxxxx. There is documentation that the claimant has underlying psychological problems due to work injury sustained on xxxxx. There is no objective evidence supporting that the current psychological problems in this claimant is related to the right knee chronic pain due to injury sustained on xxxxx. Additionally, the claimant has not received a complete psychological evaluation as evidenced by a Master's level clinician performing the evaluation. Psychological testing must rule out a diagnosis of personality disorder. Best practice for this type of evaluation is the Minnesota Multiphasic Personality Inventory (current) but the license of a Master's level clinician does not allow for the administration of projective testing. There also appears to be no definitive testing to rule out



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catastrophizing, which has a known correlation with poor recovery and adjustment to chronic pain.

Based on the ODG and criteria as well as the clinical documentation and reviews stated above, the request for authorization of a Functional Restoration Program (80 hours) is not medically necessary. It is my clinical opinion that the requested service is deemed not medically necessary, and I am recommending to uphold previous adverse determination.

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)

ODG - Pain (Chronic) – Online version

Chronic pain programs (functional restoration programs)

Criteria for the general use of multidisciplinary pain management programs:



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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



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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



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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.