

# Medical Assessments, Inc.

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## Notice of Independent Review Decision

August 16, 2015

### IRO CASE #:

### DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional Restoration Program 80 hours

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

The Reviewer is a Chiropractor with over 13 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 male who was injured while changing tires on xx/xx/xx while working. At the time the claimant was injured, he was working with a piece of equipment that was new to him. It was a x which was used to lift up x which could weight up to several hundred pounds.

xxx: MRI of the lumbar spine. **Impression:** 1. Degenerative disc disease as described above most prominent at L4-5.

xxxx: Designated Doctor Examination. In conclusion, based on the interpretation of the radiologist, the presence of multiple levels of disco desiccation, multiple level of disc protrusions, and associated facet disease throughout the lumbar spine, the \_\_\_\_\_ (illegible) was most likely pre-existing and degenerative in nature rather than casualty related to the use of the lever on the x to lift a heavy \_\_\_\_\_ (illegible) based on the Bradford-Hill criteria in the ODG.

xxxx: Evaluation. **PE:** There was no swelling of his lower extremities. He was unable to squat because of pain. Heel to toe and toe to toe gait was done with difficulty secondary to the pain. There is no clonus or fasciculation's noted. His reflexes are 2+ at the knees and the ankles. Girth: The thigh is 54cm in circumference on the right and 53 cm on the left. The calf is 39.0 cm on the right and 39.5cm on the left. The ankle is 27.5 cm on the right and 27.0 cm on the left. **Muscle strength:** The abdominal flexors, hip flexors, and knee flexors and

extensions, ankle flexors and extensors, EHL and toe flexors are 5/5 on the right and the left side. On the left side there was pain with all four of the regions done, hips, knees, ankles, and toes. On the right side there was pain with the hips, knees and ankles but not with the EHL or the toe flexors. LS spine ROM: Flexion is 15 degrees and extension is 5 degrees. Right lateral flexion is 5 degrees and left lateral flexion is 10 degrees. Straight leg raise is negative on either side for radicular symptoms. He has a negative Lasegue test. The straight leg raise supine is 30 degrees on the right and 35 degrees on the left. The straight leg raise sitting is 70 degrees on the right and 60 degrees on the left. **PE to Palpation:** Claimant had diffuse pain to palpation of the low back in the paralumbar muscle bundles as well as the axial spine. He had exquisite tenderness to palpation over the L3-S1 interspinous ligament regions, especially L4-5 and 5-1. The patient had dysmetria on flexion and extension of his low back with guarding of both the left and the right side in an asymmetrical fashion and a slight torqueing of his spine to the left as he flexed. There was minimal guarding and trigger point pain to palpation in the vertebral bodies on the left and on the right side, but there was exquisite tenderness to palpation and triggering to palpation over the lumbar spine between L3 and S1. **Impression:** 1. The claimant has lumbar sprain and strain. 2. He has a herniated disc at the L4 and L5 area with an annular tear of the disc on the left side at L4 and L5 as well.

From reviewing the MRI scan, it is obvious that the patient has evidence of degenerative disc disease with disc desiccation at L2-3 and L3-4. It is interesting that at the L4-5 region, there is no discussion or mention of a desiccated disc at the L4-L5 region. In addition, at the L5-S1 region there is also no evidence of mention of a desiccated disc. In addition to the desiccated disc at the L3-4 region, mention is made of a moderate disc bulge with moderate facet disease and a mild central canal compromise. At the L4-5 region, there is no evidence of a desiccated disc. There is mention of a moderate left paracentral disc protrusion with an associated annular tear and this disc protrusion or herniated disc, which would be another name for disc protrusion, demonstrates a compression of the L4 nerve root. This is associated with mild facet disease and mild degree of central canal compromise. The L5-S1 disc demonstrates a bulge with a right lateral disc protrusion. There is no evidence of neural foraminal stenosis, and there is no evidence or mention made of a compression of a nerve root.

xxxx: X-Ray of Lumbar Min 4 views. **Impression:** 1. Mild spinous change. 2. Osteoarthritis changes posterior elements. 3. Mobility at 3 disc levels. 4. Mild scoliosis. 5. Segmentation anomaly.

xxxxx: Electromyography and Nerve Conduction Studies. Repetitive nerve stimulation revealed no abnormal incremental or decremental responses. The EMG was within normal limits in all muscles examined. **Electrodiagnostic Impression:** 1. The absent left peroneal F wave is a nonspecific findings that may indicate early root disease proximal nerve pathology (L5 most likely), especially in the presence of normal symmetric lower extremity conduction velocities. Needle electromyographic abnormalities are absent and support the lack of significance or conduction block. 2. There is an isolated finding that may indicate focal left lateral plantar neuropathy in its ankle or proximal foot segment based on the markedly attenuated motor response. 3. There is no evidence of sacral plexopathy, focal peroneal or tibial neuropathies in their knee or ankle segments, right lateral plantar neuropathy in its ankle or foot segment, lower limbs large fiber-peripheral polyneuropathy, neurothmuscular transmission defects, or myopathy. **Clinical Impression/Recommendations:** Lumbar spine neuroimaging correlation for possible structural causes of nerve root disease is advised to be considered.

xxxx: Follow up Evaluation. Claimant reported that his pain is essentially unchanged in the interval of his last visit. Pain level 4/10 but can get as bad as 7/10. Complained of ongoing catching, popping, stiffness, instability, weakness and night pain in his low back, which is radiating into the bilateral lower extremities, left more so than right. It is made worse with prolonged sitting or walking. Ankle strength is significant for left dorsiflexion of 4/5 and quad/bi-strength is significant for left 4/5/5.

xxxxx: Office visit. Current pain level: 7/10. **Medications:** Ibuprofen 800 mg, Neurontin 300mg, Norco 10mg, tramadol 50mg. Reflexes: Patellar: 2/4, Achilles 2/4. Strength: Knee extension 4/4, Gr toe dorsiflexion: 4/4. Normal lumbar active: decreased active rom with limiting of pain. ROM: Measurement: decreased active range of motion.

xxxx: Evaluation. Pain level 5-7/10. Claimant stated if he does not take his medicine that all of his pain goes up

to 7-8/10. With medicine it drops to 3-4/10. **PE:** He has significant pain in his low back to palpation with triggering and muscle spasm, both on the right and the left side of the paravertebral muscle bundles.

xxxx: Office visit. Epidural steroid transforaminal-lumbar.

xxxx: Office visit. Pain level reported 6-1/2. ROM shows flexion 54 degrees, extension 11 degrees, left and right lateral bending of 21 degrees lateral bending of 21 degrees and 22 degrees. The claimant has improvement in his body mechanics though still altered at extreme rom. Strength of the trunk is a 4+/5 reduced secondary to pain. The claimant continues with positive orthopedics as previously noted. The claimant continues to have positive straight leg raise on the left hand side at 46 degrees with a positive Bradard. Reflexes into the lower extremities show the knees are +2/+4, right Achilles +2/+4, left Achilles +1/+4. Sensory evaluation shows left side L6/S1 dysesthesin. The claimant has no evidence of clonus or fasciculation.

xxxx: Office visit. Claimant reported pain goes between a 2 and 8.

xxxx: Office visit. Claimant reported pain level 2-3/10. Without medications 6-7/10.

xxxxx: Office visit. Claimant reported pain level between 3 and 7-1/2. **Clinical impression:** Lumbar sprain-strain grade 2, rule out lumbar disc injury, lumbar radiculopathy, work-related.

xxxx: Follow up visit (Illegible)

xxxxx: Functional Capacity Evaluation. **Recommendations:** Claimant is currently overall functioning in the light category of work. Our recommendation for the claimant would be to continue his lumbar spine treatment protocol as suggested by ODG Guidelines. Claimant will benefit from a multidisciplinary program such as chronic pain management program.

xxxxxxx: Treatment Progress report. Claimant reported independent home exercise. **Injections:** Claimant received an injection, an esi for his lumbar spine. **PT:** Claimant reported PT xxxx and xxxx of xxxx post injection. **Psychotherapy:** 6 sessions completed to date during xxxxx. On the McGill questionnaire, the claimant scored a 27, which indicates normal pain for his injury. The score increased 5 points from previous score of 22. Pain scale indicated 60.5.

xxxxxx UR. Rationale for denial: This is male who was injured on xx/xx/xx. The original injury was noted to have occurred while the injured worker was in the crouching position attempting to operate a lever on a dolly. Based on the documentation that has been provided, the injured worker meets the criteria as outlined below. Specifically, multiple conservative modalities have been attempted and failed to substantially improve the injured worker. The guidelines coordinating our trial period with documentation of objective functional improvement additional hours may be supported if a peer conservation is achieved and this partial certification is agreed upon. However, no such conversation took place and therefore, this cannot be considered partially medically necessary.

xxxxx: UR. Rationale for denial: This is male who sustained an injury on xx/xx/xx. The stated mechanism of injury was operating a dolly. A noted dated xxxxx indicates that symptoms had resolved with pt. but returned when the injured employee resumed working. A previous functional capacity evaluation found the injured employee to be functioning at the light physical demand level. Previous treatment was stated to include medications, pt., and epidural steroid injections without substantial improvement. A designated doctor examination dated xxxxxx stated there was no evidence of a lumbar radiculopathy and that the degenerative changes found on the lumbar spine MRI were likely due to normal life rather than a traumatic cause from a work-related injury. An evaluation performed on xxxxx revealed normal rom of the lumbar spine without spasms and normal strength and sensation. The injured employee was determined to be at maximum medical improvement with a 0% impairment rating. The claimant is off work, claimant has been terminated, claimant must reply to job. Disc herniation is present and sprain strain is the only diagnosis being accepted by workers' comp at this time. Based on no job to return to, the program was requested over work hardening. There is no co morbidity

problems stated at this time. Medication reduction plan is part of the program as well. Six sessions of individual psychotherapy and has had progress. After his detailed discussion, the claimant has had abundant pt. and individual psychotherapy sessions. The claimant has appeared to plateaued, therefore no more treatment or modalities are medically indicated at this time. Therefore this request remains not medically necessary.

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

The previous determination has been upheld. The claimant is a male who injured himself at work on xx/xx/xx. Based on the records, the mechanism of injury was the claimant was changing x at work with a piece of new equipment which was x when he felt pain in his lower back. MRI of the lumbar spine on xxxx shows degenerative disc disease as described above the most prominent at L4-L5. On xxxxx, the evaluation shows that the claimant was unable to squat, heel to toe was performed but with difficulty. No neurological deficits were noted. DTRs, mm testing, and girth measurements were normal. SLR and Lasegue were normal bilaterally. ROM was decreased and TTP of lumbar spine was noted. Impression was lumbar sprain/strain, and a noted herniated disc at the L4 and L5 area with annular tear of the disc on the left side at L4 and L5 as well. On xxxxx, the electromyography and NCV studies revealed the absent left peroneal F wave is a nonspecific findings that *may* indicate early root disease proximal nerve pathology (L5 *most likely*). On xxxx, the office visit note shows current subjective pain is 7/10. Reflexes were normal, and muscle strength was normal. AROM was decreased due to pain. Medications were described as Ibuprofen 8000 mg, Neurontin 300 mg, Norco 10mg, and Tramadol 50 mg. On xxxxx, the office visit note shows that the claimant received an ESI- lumbar.

On xxxxx, the DD examination shows that there was no evidence of lumbar radiculopathy and that the degenerative changes found in the lumbar spine MRI were likely due to normal life rather than traumatic cause from a work related injury. On xxxx, a FCE was performed and shows that the claimant is functioning in the light PDL capacity. Recommendation was given for a multidisciplinary program such as a Chronic Pain management program. On xxxx, evaluation by, MS, LPC reveals that the claimant is performing an independent home exercise program, and claimant has received 6 sessions of PT in xxxxx. On the McGill questionnaire, the claimant scored a 27, which indicates normal pain for his injury. The score increased 5 points from previous score of 22.

After reviewing the medical documentation, and based on my clinical experience, the request for 80 hours of Functional Restoration program is not supported by the ODG guidelines. No co-morbidities are present in the medical documentation. No neurological deficits are consistent throughout the treatment as noted by the physician notes. The claimant was utilizing an independent home exercise program as noted on xxxxx. Functional restoration program is recommended in selected patients with chronic disabling pain. Based on the medical records reviewed, and the FCE dated xxxxx, the claimant is not disabled because he was able to perform at light PDL, therefore the request for Functional Restoration Program 80 hours is not recommended and the review is upheld.

ODG Guidelines:

#### **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)**