IRO NOTICE OF DECISION TEMPLATE – WC

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DATE: March 1, 2016

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Functional Restoration Program 80 HRS

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 Orthopedic Surgery with over 42 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 injured his right knee when he was working, and he slipped and fell onto his right knee while it was raining on XX/XX/XX.

XX/XX/XX: The claimant was evaluated for Maximum Medical Improvement, Impairment Rating, and an Extent of Injury for a Knee contusion. The patient indicated he was helping children cross the street as a crossing guard on a rainy day, when he slipped and fell onto his right side, injuring his right hip, right knee, and right elbow. He stated to have fallen with open legs. The diagnostic studies are reviewed as follows: X-ray of the left hip, indicating no evidence for an acute fracture. Mild osteoarthritis of the left hip joint. X-ray of the right hip, indicating mild hip joint space narrowing suggestive of osteoarthritis. No evidence for acute fracture or dislocation. X-ray of the right knee, indicating no evidence for acute fracture or a joint effusion. Non-specific pretibial soft tissue swelling suggesting contusion or Prepatellar bursitis. MRI of the left groin revealing a large left inguinal hernia. No inguinal mass or lymph node enlargement. No soft tissue hepatoma. The extensor and flexor muscle bundles of the left hip joint are normal. No fracture of the hip or pelvis is seen. MRI of the right groin revealed a small right inguinal hernia. No inguinal mass or lymph node enlargement. Hydrocele of the right scrotum was noted. No pelvic fracture seen. No intramuscular hemorrhage or edema present. MRI of the right knee indicated an oblique tear through the body of the lateral meniscus is seen communicating with the femoral surface. Grade II degenerative change of the medial meniscus is seen. A mild joint effusion with a small Baker's cyst is noted. No acute ligamentous strain or tear is seen. No occult bone injury or osteochondral fracture is noted. The patellofemoral joint is intact. The claimant indicated that he had several sessions of physical therapy and chiropractic care. He also indicated that he had one trigger point injection with no change in his condition. He presented with pelvis, left hip and left knee pain. Patient also indicated left leg weakness and numbness with weather changes, standing, walking, carrying, and bending increasing his pain. Cold packs, medication, rest, massage, and physical therapy help to decrease his pain. Testing of the bilateral lower

extremities revealed sensation/motor testing within normal limits. The patient was unable to perform heel and toe walk. RATIONALE indicated that patient was evaluated with reports of bilateral groin and right knee pain. Range of motion was within normal limits and patient was released from care. No further treatment was noted until he presented for evaluation with a different provider. This was the first indication of a right elbow injury, which was not reported until 1 ½ months later so therefore, it is not related to the injury. The examinee had x-rays the following day, which support the findings of a bilateral hip, thigh, and groin sprain/strain. Previous MMI indicated the examinee had reached MMI on XX/XX/XX and assigned no impairment rating. MMI DATE AS ASSIGNED PER THIS EXAMINATION AND THIS EVALUATOR: Clinically on XX/XX/XX RATIONALE: For the right knee contusion, the examinee is at MMI on XX/XX/XX. He was cleared by his physician at that time. Full range of motion was noted at that time. The examinee did suffer an injury, so an impairment rating is warranted. He has full range motion and strength, so a 0% is warranted.

XX/XX/XX: DDE: MMI DATE AS ASSIGNED PER THIS EXAMINATION AND THIS EVALUATOR: The patient has continued therapy for sprains/strains and elbow contusion until the time of examination today. He has full range of motion and strength with only subjective reports of pain, likely related to degenerative changes noted on x-rays and MRI which are not related to his injury. No further treatment is warranted for the sprains/strains based on his current examination. He is at MMI of today's examination.

XX/XX/XX: Claimant was evaluated for reports of limitations in intrinsic physical activities including prolonged, standing, walking, stopping, squatting, kneeling, bending, twisting, and leaning due to knee pain and groin pain. He reported limitations in functional physical activities including carrying, lifting, pushing, pulling, and ascending/descending stairs due to knee pain. He complains of pain with weight bearing in both knees but does not walk on a bent knee on either side. He reports popping and grinding in both knees. He reports stiffness in both knees while riding in a car accompanied by pain. Both of his knees swell. He does not trust either because they give way. Pain in both knees cause him to awaken at night. He can ascend and descend stairs but hold the handrail. He does not have full motion in either knee. He can squat but reports pain in both knees. McMurray's sign is negative both medially and laterally on the right and the left knee. There is no audible or palpable clicking. Bilaterally there is no swelling or effusion. Patellar tracking is normal with slight crepitus. The medial and lateral joint lines are non-tender. Anterior and posterior drawer is negative. Vargas/valgus stress testing is 0. There is no medial, lateral, anterior, or posterior laxity or instability in the knee which is stable. Collateral ligaments are stable. Assessment is right knee contusion, hip, thigh, and groin sprain/strain, left inguinal hernia, and right inguinal hernia/ hydrocele. Extent of injury states as follows: The compensable injury is disputed. The carrier-accepted compensable injury includes a right knee contusion. Additionally claimed injuries include hip sprain/strain, thigh sprain/strain, groin sprain/strain, and elbow contusion. The description of the injury is consistent throughout the medical records. The claimant slipped on the wet floor. This caused the claimant to do the splits and injure himself.

XX/XX/XX: Claimant was seen by unknown physician where he presented for a follow up evaluation. He had recently underwent surgery to correct bilateral inguinal hernias that he suffered as a result of a fall he took while working. He is recovering well. His gait on examination was slow, unsteady, and painful, but he reported improvement than prior to the surgery. Before, he was unable to walk without the assistance of a cane. Now, he can do so without one. Plan was to start his therapy treatments the upcoming week.

XX/XX/XX: Claimant was seen for a Comprehensive Functional Capacity Evaluation where based upon his physical assessment and work demand, he was considered not capable of physically performing all of his pre-injury work demands. In general, XX work physical demand levels (PDL) for lifting are in the Light PDL (25-50lbs). His present functional abilities are in the less than sedentary PDL (0lbs.) at this time. XX is not currently meeting all of his pre-injury lifting demands. Functionally he is not meeting all of his job requirements. He had complaints of pain sensations of a 6/10 to 7/10 during testing and exhibited outward pain behavior patterns and acute distress. His subjective complaints are consistent with clinical observations of function and mobility. It was recommended at this time that the claimant was recommended to transition to a Chronic Pain Management/Functional Restoration program to address his physical and functional deficits.

XX/XX/XX: Claimant was seen in the office. At that time, XX BDI score was an 8, which is an 8-point decrease from his

previous score of 16. His BAI is a 22. It was again recommended that he participate in the FRP to "provide the emotional support that he needs as he has returned to work and continues to recover from his work related injury." He continued to have pain problems, physical functioning deficits, and psychological issues.

XX/XX/XX: UR. RATIONALE: When noting the date of injury, the injury sustained, the treatment to date, and the findings noted with the post-designated doctor evaluation, there is no clear clinical indication presented to suggest the need for an additional functional restoration program. This is an individual who sustained minor contusions. There is nothing to suggest any additional functional improvement will be gained with this protocol.

XX/XX/XX: UR. RATIONALE: It is unclear why there is a request for participation in a functional restoration program at this time. A Designated Doctor Examination has stated that the injured employee had only sustained various sprain/strain injuries as well as a hernia and right knee contusion. There was an essentially normal physical examination on this date. There is no diagnosis of femur fracture on objective studies. A sprain/strain as well as a contusion would certainly have resolved in the XX months since the date of injury. As such, it is unclear why the injured employee claims to have such pain and disability. Considering these findings, previous treatment rendered, and diagnoses this request for a functional restoration program is not medically necessary.

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

The previous adverse decisions are upheld. The claimant was been noted to have sustained a sprain/strain and knee contusion. He has participated in chiropractic and physical therapy and has undergone trigger point injection. He has had unremarkable physical examinations. Radiologic studies have demonstrated no fractures. It has been over a year since the injury, which is more than the medically accepted time frame for healing of the sustained injury. The ODG state there must be loss of function, which is not evident in this case. Therefore, the request for Functional Restoration Program 80 HRS is not medically necessary.

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) Early rehabilitation is more likely to be a cost-effective compared to receiving functional restoration as a treatment of last resort. (Theodore, 2014) 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.
Chronic pain programs (functional restoration 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 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.

IRO REVIEWER REPORT TEMPLATE -WC

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)**