

# Medical Assessments, Inc.

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## IRO CASE #:

## DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Functional Restoration Program 10 Days-97799

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

The Reviewer is Board Certified in the area of Physical Medicine and Rehabilitation with over 16 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 when a cabinet fell on him on XX/XX/XX. Current diagnoses includes lumbar sprain.

XX/XX/XX: Physical Performance Evaluation. The claimant's job PDL: Medium. The claimant is currently overall functioning in the light category of work. **Recommendations:** The claimant will benefit from a multidisciplinary program such as a chronic pain management program.

XX/XX/XX: Physical Performance Evaluation. The claimants Job PDL: Medium. The claimant is currently overall functioning in the medium category of work and he continues to demonstrate altered body mechanics, strength and limited ROM of his bilateral lower extremity. Our recommendation for this claimant would be to continue his lumbar spine treatment protocol. The patient would benefit from an additional ten days of the functional restoration program.

XX/XX/XX: Treatment Progress Report. **Medications:** Ibuprofen 800mg, Lyrica 75mg, Flexril 10mg, Enalapril 10mg, Atorvastatin 20 mg. Lyrica was decreased to 75mg 1 tab at night and Flexril was decreased to 2 x daily. The recommendation for the claimant is to continue with an additional 10 days of the functional restoration program. The claimant believes an additional 10 days will allow him to perform at the physical level he will progress to with continuation of the program.

XX/XX/XX: UR. Rationale for denial: The claimant is a male who reported an injury on XX/XX/XX. The mechanism

of injury reportedly occurred when the patient was pushing a heavy cabinet, when it fell he twisted to keep it from falling on him. His diagnoses were noted as sprain of ligaments of the lumbar spine. MRI of the cervical preformed on noted to reveal changes of cervical spondylosis at the C3-4, C4-5, C5-6 and C6-7 levels. MRI of the left shoulder performed on XX/XX/XX, revealed acromioclavicular ligament high grade strain with soft tissue contusion and moderate biceps tendinitis. MRI of the right shoulder performed on XX/XX/XX revealed rotator cuff tendinopathy involving the distal fibers of the supraspinatus tendon, the subacromial bursitis and high grade biceps tendinitis. MRI of the lumbar spine performed on XX/XX/XX revealed large disc herniation at L5-S1 effacing the S1 nerve roots and disc herniation with spondylolisthesis at L4-5 and disc protrusion at L3-4. An EMG/NCV study performed on XX/XX/XX revealed normal study with no electrodiagnostic evidence of either a right or left lower extremity radiculopathy, plexopathy, or polyneuropathy. The claimant continued with pain despite multiple therapies including aquatic therapy, injections, PT and ultrasound. It was noted the job PDL for the claimant is medium and he is currently functioning in the medium PDL. His floor level capacity was 30 pounds limited secondary to pain, shoulder level was 25 pounds and overhead level with lifting capacity was 25 pounds. The clinical information indicated the claimant completed a previous functional restoration program with improvements of pain, depression, anxiety and capacity. However, the exact number of sessions completed to date was not specified to indicate the duration of previous treatment. Therefore, the request for Functional Restoration Program x 10 Days is non-certified.

XX/XX/XX: UR. Rationale for denial: The claimant is a male who sustained an injury when a cabinet slipped and fell on him XX/XX/XX. Current diagnosis includes lumbar sprain. The claimant received bilateral L5 and S1 medial branch radiofrequency neurotomy on XX/XX/XX and XX/XX/XX. The claimant had a BAI score of 15 from 12. The claimant was recently prescribed Mobic 7.5 to help with his ongoing pain symptoms. Per ODG treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The claimant completed 80 hours of Function Restoration Program. The claimant demonstrated improvement in function and psychological scores. However, he already meets his job requirement of Medium PDI. There was no indication of significant functional deficits which would warrant continued participation in the multidisciplinary treatment program. Thus, the medial necessity of the request is not substantiated and the previous determination is upheld.

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

The previous determination has been upheld. Denial of an additional 10 days/80 hours of Functional Restoration Program is upheld. There has been documented physical and psychological improvements within required Medium functional demand level. Therefore, the request for Functional Restoration Program 10 Days is non-certified.

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)