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Description of the service or services in dispute:

Chronic pain program 10 sessions / 80 units, three times a week for XX knee

Description of the qualifications for each physician or other health care provider who reviewed the decision: Board Certified Anesthesiologist

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☐ Overturned (Disagree)
- ☑ Upheld (Agree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

XXXX. The diagnosis was contusion of XX XX leg, subsequent encounter (XX.XX).

Per a Behavioral Evaluation dated XXXX, the pain resulting from XXXX injury had severely impacted normal functioning, physically and interpersonally. XXXX reported frustration and anger related to the pain and pain behavior, in addition to a decreased ability to manage pain. XXXX reported high stress resulting in all major life areas. XXXX would benefit from a course of pain management, as it would improve XXXX ability to cope with pain, anxiety, frustration, and stressors, which appeared to be impacting XXXX daily functioning. XXXX should be treated daily in a pain management program with both behavioral and physical modalities as well as medication monitoring. XXXX reported that XXXX met XXXX job demands in a heavy physical demand level. XXXX was unable to achieve 100% of the physical demands of XXXX job.

A functional capacity evaluation was completed on XXXX to determine XXXX overall musculoskeletal and functional abilities as it related to the physical demands. XXXX

demonstrated the ability to perform XX.XX% of the physical demands of XXXX job as a XXXX. XXXX was unable to achieve the return to work test items successfully during this evaluation including squatting, walking, stair climbing, and total standing and at one time standing. XXXX demonstrated the ability to perform within the heavy physical demand category. XXXX was wearing a neoprene brace on the XX knee. XXXX walked with a slight limp due to pain and discomfort of the XX knee. XXXX met XXXX job demand of static balancing. XXXX had significant instability on the XX leg standing than the XX. When XXXX stood on the XX leg, a "rocking" motion was noted in the XX leg / ankle. Walking was very difficult for XXXX. Fatigue, pain increase and increase in limping on the XX leg occurred with walking, squatting and standing. In cardiovascular testing, XXXX completed five minutes on the treadmill at a 1.5 speed. XXXX met all XXXX job demands of XXXX. However, during the unilateral lift on the XX side, XXXX experienced significant instability and increased pain in the XX knee. There was a slight safety concern during the XX-sided unilateral lift due to instability of the XX knee. The shoulder lift in XXXX was also challenging for XXXX due to instability and the weight load into the XX knee. The pain seemed to increase during XXXX when more weightbearing tasks were performed on the XX side / knee. XXXX was reliable and consistent with the pain. Walking, standing frequently and weightbearing non and XXXX on the XX knee was significantly hindering XXXX functional ability. Even though XXXX met XXXX job demands in XXXX, XXXX needed adequate rest between lifting, walking and standing especially with the instability of the XX knee. During this evaluation, XXXX was unable to achieve 100% of the physical demands of XXXX job / occupation. The limiting factors noted during these objective functional tests including extraordinary muscle recruitment, inadequate strength, and safety concern.

XXXX was seen by XXXX for XX XX pain. XXXX was able to stand and walk for less than 15 minutes and sit for less than 30 minutes. The pain was rated as XX-XX/XX and XX-XX/XX at its worst. XXXX had constant shooting and tingling pain and numbness. Knee brace and ice pack made the pain better and standing, sitting, and walking made the pain worse. Examination showed diminished XX deep tendon reflexes and decreased range of motion of the XX knee.

The treatment to date included medications and physical therapy with minimal or no help.

Per a utilization review decision letter dated XXXX, the requested service of chronic pain program 10 sessions / 80 units, three times a week for the XX knee was denied. Rationale: "Based upon the medical documentation presently available for review, the guideline referenced would not support a medical necessity for this specific request. This reference would not presently support a medical necessity for this specific request

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as there is a documentation to indicate that a recent functional capacity evaluation revealed that there was an ability to perform pre-injury work activities. Additionally, the submitted clinical documentation does not indicate that prescription medications are required for management of pain symptoms. The case was discussed with XXXX, a designated representative. XXXX reports that the claimant is not presently on medications for management of pain symptoms. Consequently, based upon the medical documentation available for review, medical necessity for such an extensive program as requested is not established for the described medical situation."

Per a utilization review decision letter dated XXXX, the appeal request was not recommended as medically necessary. Rationale: "The initial request was non-certified noting that there is a documentation to indicate that a recent functional capacity evaluation revealed that there was an ability to perform pre-injury work activities. Additionally, the submitted clinical documentation does not indicate that prescription medications are required for management of pain symptoms. Appeal dated XXXX indicates that the patient was unable to achieve 100T of the physical demands of XXXX job / occupation. The patient is not being prescribed any medication, which is not XXXX fault. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient presents with only mild XX and XX. A functional capacity evaluation dated XXXX indicated that the patient's required and current physical demand level (PDL) are both heavy. The patient is not currently taking pain medication. Therefore, medical necessity is not established in accordance with current evidence-based guidelines and the request is therefore non-certified."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

This patient is under consideration for a chronic pain program. The providers have performed a comprehensive multidisciplinary pain evaluation which has identified the patient's functional limitations as well as XXXX current pain symptoms. Two prior utilization reviews were performed but could not approve the requested chronic pain grow program citing deficiencies in the patient's symptomatology relative to the official disability guidelines. The main issue at hand here is the patient's return to work as a XXXX. A functional capacity evaluation demonstrated that the patient was able to perform XX.XX% of the physical demands of XXXX work as a XXXX. There were some limitations to XXXX activity abilities. XXXX is able to perform within the heavy physical demand category based on the definitions developed by the US Department of Labor. The functional capacity evaluation also identified that is able to work full-time with the need to alternate sitting and standing. The functional capacity evaluation all so found that the patient had some instability of the knee. Of note, the patient does not have any

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major XX or other affective disorders. What is noticed in this case is that the patient is not taking any pain medications. So it is unclear why the patient has elected not to take pain medications, and seeks another program that will control XXXX pain. The ODG requires that lower levels of care be provided. The absence of analgesic medications would qualify as a lower level of care. So it is unclear what a chronic pain program would achieve for this patient in terms of improving XXXX functional abilities. XXXX has achieved XX% of XXXX activity levels. It is also unclear how XXXX pain management may be improved, particularly if XXXX's not taking an analgesic medications. Given the documentation available, the requested service(s) is considered not medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain
- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
  Pain Chapter

Chronic pain programs (functional restoration programs)

Recommended where there is access to programs with proven successful outcomes (i.e., decreased pain and medication use, improved function and return to work, decreased utilization of the health care system), for patients with conditions that have resulted in "Delayed recovery."

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(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.

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(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 more than 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).

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(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.

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(2) the group of patients that benefit most from this treatment; (3) the ideal timing of when to initiate treatment; (4) the intensity necessary for effective treatment; and (5) cost-effectiveness. It has been suggested that interdisciplinary/multidisciplinary care models for treatment of chronic pain may be the most effective way to treat this condition. (Flor, 1992) (Gallagher, 1999) (Guzman, 2001) (Gross, 2005) (Sullivan, 2005) (Dysvik, 2005) (Airaksinen, 2006) (Schonstein, 2003) (Sanders, 2005) (Patrick, 2004) (Buchner, 2006) These treatment modalities are based on the biopsychosocial model, one that views pain and disability in terms of the interaction between physiological, psychological and social factors. (Gatchel, 2005)

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(1) Multidisciplinary programs: Involves one or two specialists directing the services of a number of team members, with these specialists often having independent goals. These programs can be further subdivided into four levels of pain programs:

(a) Multidisciplinary pain centers (generally associated with academic centers and include research as part of their focus)

(b) Multidisciplinary pain clinics

(c) Pain clinics

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(d) Modality-oriented clinics

(2) Interdisciplinary pain programs: Involves a team approach that is outcome focused and coordinated and offers goal-oriented interdisciplinary services. Communication on a minimum of a weekly basis is emphasized. The most intensive of these programs is referred to as a Functional Restoration Program, with a major emphasis on maximizing function versus minimizing pain. See Functional restoration programs.

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Outcomes (in terms of body parts)

Shoulder (and other upper extremity disorders): This large cohort study concluded that an interdisciplinary functional restoration program (FRP) is equally effective for patients with chronic upper extremity disorders, including the elbow, shoulder and wrist/hand, as for patients with XX spine disorders, regardless of the injury type, site in the upper extremity, or the disparity in injury-specific and XX factors identified before treatment. (Howard, 2012)

Knee (and other lower extremity disorders): This cohort study demonstrated that FRP was equally efficacious for patients with chronic XX XX (XX) injuries (involving the hip, knee, ankle, and foot) and XX XX pain (XX) injuries. Both patient groups significantly improved on measures of pain, disability, and XX after the FRP, and patients in both groups displayed similarly high return-to-work and work-retention rates one year later. (Mayer, 2013)

XX (and XX XX): There are limited studies about the efficacy of chronic pain programs for XX disorders. (Karjalainen, 2003) This may be because rates of XX claims are only 20-25% of the rates of XX claims. In addition, little is known as to chronicity of outcomes. Researchers using PRIDE Program (Progressive Rehabilitation Institute of Dallas for Ergonomics) data compared a cohort of patients with XX XX disorders to those with lumbar spine disorders from 1990-1995 and found that they had similar outcomes. XX patients were statistically less likely to have undergone pre-rehabilitative surgery. (Wright, 1999) Interdisciplinary functional restoration programs (FRPs) are equally efficacious for treating both chronic occupational XX and XX disorders, and FRPs are equally effective, irrespective of the compensable body part(s). (Hartzell, 2014)

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Predictors of success and failure: As noted, one of the criticisms of interdisciplinary/multidisciplinary rehabilitation programs is the lack of an appropriate screening tool to help to determine who will most benefit from this treatment. Retrospective research has examined decreased rates of completion of functional restoration programs, and there is ongoing research to evaluate screening tools prior to entry. (Gatchel, 2006) There is need for research in terms of necessity and/or effectiveness of counseling for patients considered to be "at-risk" for post-discharge problems. (Proctor, 2004) XX

Role of duration of disability: There is little research as to the success of return to work with functional restoration programs in long-term disabled patients (> 24 months).

Studies supporting programs for patients with long-term disability: Long-term disabled patients (at least 18 months) vs. short-term disabled (4 to 8 months) were evaluated using Pride data (1990-1993). No control was given for patients that did not undergo a program. During the time studied program dropouts averaged 8% to 12%. (It does appear that at the time of this study, participants in the program were detoxified from opioids prior to beginning.) The long-term disabled group was more likely to have undergone spinal surgery, with this likelihood increasing with time. Return to work was statistically different between the short-term disabled (93%) and the long-term disabled-18 months (80%). The long-term disabled-24 months group had a 75% return to work. Long-term disabled-18 month patients were statistically more likely to visit new health providers than short-term disabled patients (34% and 25% respectively). Work retention at one year in groups up to 24 months duration of disability was 80%. This dropped to 66% in the group that had been disabled for > 24 months. The percentage of recurrent lost time injury claims increased from around 1% in the groups disabled for < 35 months to 8.3% in the groups disabled for > 36 months. A main criterion for success appeared to be the decision of the patient to actively participate in the program rehabilitation goals. (Jordan, 1998)

Studies suggesting limited results in patients with long-term disability: While early studies have suggested that time out-of-work is a predictor of success for occupational outcomes, these studies have flaws when an attempt is made to apply them to chronic pain programs. (Gallagher, 1989) (Beals, 1972) (Krause, 1994) Washington State studied the role of duration of work injury on outcome using a statistical model that allowed for a comparison of patients that participated in a multidisciplinary pain program (using data from 1991-1993) vs. those that were evaluated and not treated. This was not an actual study of time of disability, but of duration of injury (mean years from injury to evaluation of 2.6 years for the treated group and 4.0 years for the evaluated only group). The original statistical analysis allowed for a patient to be included in a "treated group" for those individuals that both completed and did not complete the program. Data was collected from 10 sites. Each of the centers was CARF approved and included Pysch/behavioral treatment, vocation counseling and physical therapy. A sub-study evaluated a comparison of patients that were treatment completers vs. those that did not participate (78.6%, N-=963). No information was given in terms of surgical procedures or medications. The primary outcome was time loss status of subjects 2 years after they had undergone the index pain center evaluation. In the 2001 study, if chronicity of duration of injury was controlled for, there was no significant benefit produced in terms of patients that were receiving time-loss benefits at 2-years post treatment between the two groups. Approximately 60% of both groups were not receiving benefits at the two-year period. As noted, the "treated patient" was only guaranteed to have started a program. A repeat analysis of only the patients who completed the study did not significantly change the results of the study. In a 2004 survey follow-up, no significant difference was found between treated and untreated groups, although the treated group had better response. The survey response was 50%, and the treatment responders were more likely to be disabled at the time of the survey. The authors suggest that the results indicated early intervention was a key to response of the programs, and that modest goals (improvement, not cure) be introduced.

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(Robinson, 2004) (Robinson, 2001) [The authors also concluded that there was no evidence that pain center treatment affects either disability status or clinical status of injured workers.]

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☐ Pressley Reed, the Medical Disability Advisor

☐ Texas Guidelines for Chiropractic Quality Assurance and 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)

Appeal Information

You have the right to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance
Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at 1-800-252-7031.

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