Parker Healthcare Management Organization, Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MARCH 3, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Medical necessity of proposed Functional restoration program (97799) X 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 Medical Doctor licensed by the Texas State Board of Medical Examiners. The reviewer specializes in Physical Medicine and Rehabilitation and is engaged in the full time practice of medicine.

REVIEW OUTCOME

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

XX Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Primary Diagnosis	Service being Denied	Billing Modifier	Type of Review	Units	Date(s) of Service	Amount Billed	Date of Injury	DWC Claim#	IRO Decision
unk	97799		Prosp	80 hours			Xx/xx/xx	Y03C18924	Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee is a gentleman who reported low back pain on xx/xx/xx. He was working and lifting boxes. The past medical history was significant for hypertension and type 1 Diabetes.

The injured employee was initially off work for two weeks, and then returned to light duty performing office work. Initial x-rays reported no fractures. A lumbar MRI in June of 2013 reported degenerative disc disease with bulges and foraminal encroachment bilaterally at L4 through S1, although this report was not included in the medical records. A lower extremity electromyogram in July of 2013 apparently suggested an acute L5 radiculopathy and polyneuropathy, but the report was not included in the medical records.

The injured employee underwent an epidural steroid injection in 2013 and this reportedly helped for a few days.

The injured employee had a Designated Doctor Evaluation in February of 2014. It was determined that the injured employee had reached Maximum Medical Improvement and was given a 5% whole person impairment rating.

In an orthopedic consultation in March of 2014, recommended an L4 through S1 decompression, which was denied.

The injured employee had a month of reconditioning on a three times per week basis and had two weeks of daily work hardening approved and this ended in March of 2014 with limited improvement.

on January 9, 2015, performed a medical evaluation. There were subjective complaints of low back pain radiating to both feet. There were subjective complaints of weakness, numbness, and tingling in both legs. The injured employee denied bowel or bladder complaints. The current medication included Flexeril, Aleve, and ketamine cream. A Beck Depression Inventory was rated 14, with mild depressive symptoms. On physical examination, the injured employee was 65 inches tall and weighed 180 pounds. The neurological examination reported good coordination with no objective deficits of strength, sensation, or reflexes. The extremities showed good stability and range of motion without deformity, malalignment, effusion, or contractures. There was normal gait with good heel and toe walking. There was tenderness of the lumbar spine extending from L4 through the sacrum and sacroiliac joints, including the upper buttocks. There were 20° of flexion, 5° of extension, and 10° of lateral bending bilaterally, with pain. Straight leg raise testing was positive at 45° bilaterally with low back pain and negative Lasegue's test without verifiable neurologic findings. The clinical assessment was the accepted diagnosis of chronic bilateral lumbar radicular pain with sprain, and current physical examination findings of severe muscle guarding and mobility deficits, without specific segmental rigidity or verifiable radiculopathy, but with electromyogram findings suggesting L5 radiculopathy by history with no records available; noncompensable deconditioning syndrome; and noncompensable chronic pain syndrome. The recommendation was for an Interdisciplinary Evaluation and a Functional Capacity Evaluation.

On an initial Physical Therapy Evaluation on January 9, 2015, there was normal gait and posture. There was decreased range of motion of the lumbar spine. There was tenderness along the lumbar paraspinous muscles. The recommendation was for physical therapy.

On a follow-up on January 13, 2015, it was noted that the injured employee's job requirements were for a heavy physical demand level job, and his current physical demand level was noted to be below sedentary. The injured employee's Global Assessment of Functioning score was 50 with moderate stressors (PSS of 3), mild-to-moderate depressive symptoms (IDS of 18), extreme fear avoidance (FACS 85/100), severe central sensitization (CSI of 50/100), and a moderate clinical insomnia (ISI of 15/28). The recommendation was for an initial 80 hours of a functional restoration program, Cymbalta, Lunesta, Naprosyn, and Flexeril.

In a preauthorization request, on January 20, 2015, stated the case had been reviewed with a Designated Representative. It was stated that after reviewing the case with the Designated Representative, the medical necessity for the specific request had not been established. The above noted reference would not support this request to be one of medical necessity as it documented the injured employee was previously provided access to tertiary level of care in the form of a work-hardening program. stated, as such, that presently, medical necessity for the specific request had not been established for the described medical situation.

In a Reconsideration Letter on January 23, 2015, he stated that the Official Disability Guidelines

would approve the request for an additional 80 hours of a functional restoration program. It was stated that the injured employee has high motivation for work demonstrated by continuing with light duty for 16 of the
20 months since the injury with the employer of injury. noted the mismatch between the heavy physical demand level of his job and his current below sedentary performance. It was noted that the injured employee has extreme fear-avoidance (FACS of 85/100) creating inhibition of physical function and explaining partially the reason for the inability to return to full duty and prolonged continuous partial/total disability. His other functional comorbidities were stated to be moderate clinical insomnia (ISI of 15/28), high pain report (7/10), and some depressive symptoms (IDS of 18). noted the injured employee had experienced failure of one month of physical therapy reconditioning, two weeks of work hardening, injections, and pharmacotherapy to resolve his disabilities.

On a follow-up on February 3, 2015, there were subjective complaints of low back pain radiating to both feet. On physical examination, there was good coordination with no objective deficit of strength, sensation, or reflexes. The extremity joints showed good stability and range of motion, without deformity, malalignment, effusion, or contractures. The lumbar spine demonstrated segmental rigidity at L4 through S1, unchanged with painful left straight leg raise testing. The current medication included Cymbalta.

A preauthorization request on February 3, 2015, stated that the request for functional restoration program x 80 hours was not supported. It was stated that, while it was understood that the injured employee continued to be symptomatic, it had been documented that the injured employee had undergone a work-hardening program. It was pointed out that repetition of the same or a similar rehabilitation program is not medically warranted for the same condition or injury. said he had discussed the case who had no additional clinical information to provide to support the request. The request for a functional restoration program when the injured employee had previously attended a work-hardening program would not be supported and was not in accordance with the guidelines, and therefore, the request was not certified.

In an Appeal Letter on February 6, 2015, he stated documentation had been provided to support a functional restoration program based on a complete medical history and physical and Interdisciplinary Evaluation including a Functional Capacity Evaluation to document physical risk factors and a mental health evaluation to document psychosocial comorbidities. The recommendation was for a functional restoration program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION. IF THERE WAS ANY DIVERGENCE FROM DWC'S POLICIES/GUIDLEINES OR THE NETWORK'S TREATMENT GUIDELINES, THEN INDICATE BELOW WITH EXPLANATION.

RATIONALE:
As noted in the Division-mandated Official Disability Guidelines Pain Chapter, updated February 23, 2015, 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). This injured employee has had two weeks of a work-hardening program previously with no documentation of increased function, the ability to return to work without restrictions, or decreased pain. The medical necessity of the proposed functional restoration program x 80 hours (97799) is not medically supported.

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).

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

XX DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

XX MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

XX ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES