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Notice of Independent Review Decision

IRO REVIEWER REPORT

Date: 1/8/2019 AMENDED 2/13/2019

IRO CASE #: XX

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: XX hours of a functional restoration program, chronic pain management program

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: Pain Medicine, Physical Medicine & Rehab

REVIEW OUTCOME:

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

☐ Overturned	Disagree
☐ Partially Overturned	Agree in part/Disagree in part
☒ Upheld	Agree

PATIENT CLINICAL HISTORY [SUMMARY]: XX. XX XX is a XX-year-old XX who was injured XX at XX on XX. XX reported that XX was XX a XX when XX XX with the XX and XX XX XX against a XX. XX injured XX XX XX, XX XX, XX XX, XX, and XX XX. XX diagnosed with pain in the XX, XX XX, XX XX, XX XX, XX XX, and XX XX. Per an Industrial Rehabilitation Comprehensive Care Plan report dated XX by XX, XX. XX presented with Decreased physical/functional capabilities for return to work full duties as a Custodian to a gainful employment. XX had Decreased knowledge of body mechanics, decreased functional strength / endurance of work activities, and decreased positional tolerance. XX had also decreased and poor XX capacity. XX had

inability to perform occasional XX pounds of weight from XX to XX, XX to XX, and XX to XX. XX was unable to carry XX pounds of weight to XX XX. XX also had decreased range of motion / flexibility and decreased strength. XX had completed XX physical therapy sessions to plateau since XX. An MRI of the XX XX, XX XX and XX XX were reviewed. Orthopedic for extremities recommended injection on XX and on XX, those were denied by carrier. Orthopedic for XX recommended epidural steroid injection on XX which was denied based on extent either way. XX. XX preferred conservative management. XX opined that XX. XX was a candidate for functional restoration. On XX, XX. XX had a follow-up evaluation with XX for the continued treatment of injuries sustained on XX. XX complained of pain in the XX XX, XX XX and XX XX. The pain was described as stabbing in the XX XX XX, soreness in the XX XX anteriorly and throbbing XX XX anteriorly. The pain was constant in the XX XX, frequent in the XX XX and the XX XX. XX reported that therapy had decreased the pain and was helpful to restore function. The pain was XX by kneeling, crawling, reaching, pushing and lifting. Per the verbal report of a functional capacity evaluation, XX had not reached the necessary physical demand level (PDL). The examination showed XX distraction test was positive for XX XX joint and / or XX injury on the XX. Maximum XX XX compression test was XX for acute neuro and / or muscular injuries of the XX, XX XX test was positive for XX and / or XX injury on the XX, XX was positive for XX injury on the XX, Apley's Scratch test was positive for XX of the XX on the XX and Apley's Compression test was positive for XX and / or XX injury on the XX. XX XX evaluation showed mild-moderate spasms, mild-moderate +2 tenderness, mild-moderate tension and mild decreased range of motion posteriorly with pain. Evaluation of the XX XX showed mild-moderate spasms, mild-moderate +1 tenderness, mild-moderate tension and mild decreased range of motion anteriorly with pain. XX XX evaluation revealed mild-moderate spasms, mild-moderate tenderness, mild-moderate tension and mild decreased range of motion anteriorly with pain. XX. XX was seen for a functional capacity evaluation by an unknown provider at BTE Technologies on XX, in order to determine XX ongoing functional and return to work status. XX. XX had pain in the XX XX, the XX XX, and the XX XX. XX reported that on XX, was using a XX when XX got XX with the XX and XX XX XX XX. XX injured XX XX XX, XX XX, XX XX, XX, and XX XX. XX complained about the XX XX pain, which was aggravated with weightbearing activities and XX XX pain, which was aggravated with sustained postures. The XX XX pain was sharp and aggravated with prolonged walking. The XX pain and XX XX pain was aggravated with reaching up / overhead. XX reported that physical therapy did not help XX. XX was not working at the time. XX indicated that XX continued XX and diminished function restricted XX ability to perform all required occupational tasks and some activities of daily living. XX appeared XX during the intake process. Further, XX appeared moderately XX during the examination, as XX related moderate discomfort and displayed slight guarding of the injury site. XX demonstrated a deficit in XX XX strength, consistent effort during the testing, and deficits with respect to the compensable injury areas. XX was able to carry XX pounds for a distance of XX XX on an occasional basis. XX demonstrated normal XX and XX changes. XX had the ability to static push and static pull at a sedentary PDL. The Oswestry XX XX Disability Index and the XX Disability Index scored as severe disability. The physical activity score was 24/24, and the work activity score was 39/42. With respect to functional deficits, the most significant factors affecting XX full return to work were as follows: inability to meet minimum occupational lifting, postural, and reach up / out requirements, and high subjective pain levels associated with activity. On examination, there was tenderness to palpation to the XX and XX, XX XX supporting XX, and XX XX supporting XX. XX testing revealed 4/5 strength in the XX and XX extremities secondary to pain. XX XX range of motion showed 40 degrees flexion, 80% of normal; 50 degrees extension, 83% of normal; 30 degrees XX lateral flexion, 67% of normal; 30 degrees XX lateral flexion, 67% of normal; and bilateral rotation 50 degrees, 62% of normal. XX XX range of motion showed 45 degrees flexion, 75% of normal; 10 degrees extension, 40% of normal; 20 degrees XX lateral flexion, 80% of normal; and 20 degrees XX lateral flexion, 80% of normal. XX XX range of motion showed flexion was 120 degrees, 80% of normal and extension was 0 degrees, 100% of normal. XX XX range of motion showed flexion was 130 degrees, 87% of normal and extension 0 degrees, 100% of normal. XX and XX XX range of motion was normal. XX XX range of motion showed flexion was 150 degrees, 83% of normal; extension 40 degrees, 80% of normal; abduction 150 degrees, 83% of normal; adduction 30 degrees, 75% of normal; and internal rotation and external rotation 50 degrees, 56% of normal. XX XX range of motion showed flexion of 160 degrees, 89% of normal; extension 45 degrees, 90% of normal; abduction 167 degrees, 93% of normal; adduction 35 degrees, 88% of normal; internal rotation 75 degrees, 83% of normal; and external rotation 70 degrees, 78% of normal. For the standard XX, XX. XX displayed an average force of XX, which was considered significantly

below the normal range. XX. XX reached an average peak force of XX for the static pull strength test and XX for the static push strength test. XX. XX did not demonstrate the predictable decrease in isometric strength on the standard NIOSH strength test. XX. XX reported increased pain in the XX, XX XX, XX XX, XX XX and XX XX with static lift testing. The Oswestry XX XX Pain Disability Questionnaire revealed a total score of 13 and a disability percentage rating of 43.33%. The XX Disability Index total score was 30 and perceived disability percentage rating was 60%. On the Bruce treadmill test, XX. XX's maximum oxygen intake (VO2 max) during the Bruce treadmill protocol was XX ml/(Kg*min). When XX maximum oxygen intake is compared to XX and XX matched population norms, this corresponds to the 0th percentile, and is an XX ranking. The test was terminated due to inability to maintain pace and balance without the use of the XX. Per the report, it was opined that XX. XX would benefit from further medical intervention. It was also noted that XX. XX would be a good candidate for a functional restoration and / or transition of care program. Per the evaluation, XX. XX overall demonstrated the ability to safely and dependably perform at a sedentary physical demand level (PDL), which failed to meet the minimum job requirement for XX job and employer. XX occupation required that XX be able to safely and dependably perform at a medium PDL, per the job description provided. The results of the FCE revealed that XX. XX was able to safely and dependably perform the following: lift / carry at sedentary PDL (XX). XX could occasionally stand / walk, kneel / squat, bend / stoop, and twist. XX had difficulty reaching up / out / overhead. XX was frequently able to perform firm XX / XX. It was noted that there was a probable causal relationship between the ongoing complaint and the reported work-related injury. XX. XX passed the validity criteria, giving XX a good validity profile, which indicated that XX demonstrated maximal effort. The results could be considered valid and reliable and could be used for medical and vocational planning. Returning XX. XX to a physical demand level, which was higher than demonstrated in Functional Testing, placed XX. XX in a high-risk category for re-injury and / or exacerbation. An MRI of the XX XX performed on XX showed XX broad-based posterior XX at XX-XX, that moderately effaced the XX aspect of the XX, containing a XX, which could be suggestive of an acute injury. There was no XX compromise. An MRI of the XX XX revealed mild-to-moderate strain involving the XX tendon with a low-grade partial-thickness XX XX XX of its posterior fibers measuring XX cm XX x XX cm XX. Nondisplaced XX was present involving the XX. A small amount of fluid in the XX and there was mild-to-moderate XX involving the XX joint. Treatment to date included medications (XX, XX, XX and XX).Per a utilization review determination letter dated XX by XX, the request for a functional restoration program for XX hours was non-certified with the rationale that there was no documentation that XX. XX was not a candidate for XX levels of care such as work conditioning as required by the guidelines. Negative predictors of success were not identified in the records. There was no documentation XX. XX had the motivation to change, including changing the medication regime. Thus the request for a functional restoration program for XX hours was not certified. An appeal determination denial dated XX by XX indicated that the appeal of XX hours of functional restoration program was non-certified, with the following rationale, "The previous noncertification by XX on XX was due to lack of exhaustion of XX levels of care and lack of complete documentation. The previous noncertification is supported. Additional records included a letter on XX. XX. XX has low levels on the XX Inventory at 11, and it is not indicated why XX. XX could not undergo XX levels of care such as a work conditioning program as required by the guidelines. Negative predictors of success were not identified. There is no documentation XX. XX has a XX to change. The request for an appeal of XX hours of functional restoration program is not certified."

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

Based on the clinical information provided, the request for XX hours of a functional restoration program, chronic pain management program is not recommended as medically necessary. Per a utilization review determination letter dated XX by XX, the request for a functional restoration program for XX hours was non-certified with the rationale that there was no documentation that XX. XX was not a candidate for XX levels of care such as work conditioning as required by the guidelines. Negative predictors of success were not identified in the records. There was no documentation XX. XX had the motivation to change, including changing the medication regime. Thus the request for a functional restoration program for

XX hours was not certified. An appeal determination denial dated XX by XX indicated that the appeal of XX hours of functional restoration program was non-certified, with the following rationale, "The previous noncertification by XX on XX was due to lack of exhaustion of XX levels of care and lack of complete documentation. The previous noncertification is supported. Additional records included a letter on XX. XX. XX has low levels on the XX Inventory at 11, and it is not indicated why XX. XX could not undergo XX levels of care such as a work conditioning program as required by the guidelines. Negative predictors of success were not identified. There is no documentation XX. XX has a motivation to change. The request for an appeal of XX hours of functional restoration program is not certified." There is insufficient information to support a change in determination, and the previous non-certification is upheld. The submitted clinical records fail to establish that the patient has exhausted XX levels of care and is an appropriate candidate for this tertiary level program. There is no detailed XX evaluation submitted for review.

Addendum: Additional records were submitted for review including physical therapy notes. A XX evaluation dated XX was provided which indicates that diagnoses are XX XX, unspecified sprain of XX XX, sprain of unspecified site of XX XX, unspecified sprain of XX XX joint, XX of XX XX, sprain of XX XX and sprain of unspecified ligament of XX XX. It is unclear XX the patient has not been able to return to work given that XX injuries are all XX type injuries. There is no indication that the patient has undergone XX levels of XX treatment. It is unclear if the patient has undergone XX testing with validity measures. Given the documentation available, the requested service(s) is considered not medically necessary and the decision is upheld.

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

☒ MEDICAL JUDGMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

Pain Chapter