

# MATUTECH, INC.

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## Notice of Independent Review Decision

**DATE OF REVIEW:** June 25, 2008

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

80 units of outpatient medical rehabilitation (97799)

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

Fellow American Academy of Physical Medicine and Rehabilitation

### **REVIEW OUTCOME**

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

X Overturned (Disagree)

Medical documentation supports the medical necessity of the health care services in dispute.

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

ODG has been utilized for the denials.

### **PATIENT CLINICAL HISTORY**

#### **[SUMMARY]:**

The patient is a xx-year-old who was injured on xx/xx/xx. While stepping down, he tripped on a plank lying on the floor causing him to twist his trunk at the waist and falling down.

In September 2006, magnetic resonance imaging (MRI) of the lumbar spine revealed: (1) Mild broad-based disc bulge at L4-L5 with small central disc protrusion and annular fissure tear. (2) Small right parasagittal disc protrusion at L5-S1 minimally impressing upon the right exiting S1 nerve root.

The patient presented to D.O., with back and right leg pain. *He had*

*attended physical therapy (PT) but continued to have pain at 9/10. Dr. assessed mechanical low back pain, disc displacement at L4-L5 and L5-S1, herniated nucleus pulposus (HNP) at L5-S1 on the right, and right lower extremity radiculopathy. He prescribed Mobic and muscle relaxants and recommended epidural steroid injections (ESIs).*

In a functional capacity evaluation (FCE) performed in June 2007, the patient qualified at a light physical demand level (PDL). The evaluator felt the patient would do best with either individual physical therapy (PT) visits or work hardening. Vocational retraining was suggested. Dr. reviewed lumbar discogram/computerized tomography (CT) that revealed posterior tearing and fissuring with concordant low back pain at L4-L5 and L5-S1. He recommended lumbar surgery after psychological evaluation and dynamic x-rays.

In December 2007, M.D., evaluated the patient for worsening low back and right leg pain. Review of diagnostics revealed a bulge with tear of the L4-L5 and L5-S1 discs with the L5-S1 disc touching the right S1 nerve root. Dr. diagnosed ruptured disc at L5-S1 with impingement of the right S1 nerve root. He stated that the patient had failed conservative care and would need surgery.

In April 2008, D.C., noted the following treatment history: *Initially, the patient was treated by the company nurse. He was unable to perform modified duty and his compensation case became contested forcing him to retain an attorney. After three months and a benefit review conference (BRC) was held, the employer accepted the compensability. Following this, he attended three PT sessions and received a series of three lumbar epidural steroid injections (ESIs) providing only temporary relief of his symptoms. MRI, electromyography/nerve conduction velocity (EMG/NCV) study, and discogram/computerized tomography (CT) all confirmed posterior tearing of L4-L5 disc and small herniated disc at L5-S1 with S1 root radiculopathy. Dr. assessed lumbago, displacement of the lumbar intervertebral disc, lumbar disc syndrome with myelopathy, and pain disorder with physical impairment. He recommended outpatient medical rehabilitation (OPMR) program. In a psychological evaluation, the patient was diagnosed with pain disorder and major depressive disorder with GAF of 45. Outpatient functional restoration program consisting of cognitive rehabilitation and psychotherapy with return-to-work goal was recommended.*

In an FCE, the patient qualified at a sedentary PDL. From April through May, the patient attended 10 sessions of group medical rehab program. In a repeat FCE, the patient qualified at a medium PDL.

On April 29, 2008, the request for the lumbar trigger point injection (TPIs) was denied.

Dr. stated that the patient was not taking any prescription medications, muscle relaxants, or neuropathic medications, and stated that he would benefit from TPIs in the lumbar region, additional physical rehabilitation, and skill therapy to bring him to pre-morbid work abilities.

On May 16, 2008, request for the OPMR was denied with the following rationale: *The request for an additional 10 sessions of CPMP is not seen as medically indicated at this time. Prescription in a CPMP is reserved for patients whose other previous methods of treatment for chronic pain have been unsuccessful and there is an absence of other options likely to result in*

*significant clinical improvement. The chiropractor's notes states that TPIs would significantly improve this patient's pain behavior. Additionally, there is no documentation that the patient's psychological scores have improved in this multidisciplinary program. Finally, it is noted that the patient does not have a job to return to. Therefore the requested additional 10 sessions of CPMP are not seen as medically indicated at this time. Further clinical information insight would be necessary to establish the medical necessity of this request.*

On May 16, 2008, appealed to adverse determination of the 80 additional sessions of OPMR. Rationale: *Dr. made the referral for evaluation and treatment to an OPMR program in March 2008. He had not seen the patient since December 2007. There was no note that Dr. submitted that states "patient's treating doctor has requested trigger points." made the request for the patient to be seen by the treating doctor for an office visit and be evaluated for lumbar trigger points on April 23, 2008, to relieve active trigger points that were present and improve chronic muscle spasms. There were seven pages of psychological assessment that included Oswestry Questionnaire dated April 16,*

*2008, Beck's Depression Inventory (BDI) II, McGill Pain Questionnaire, MMPI-2*

*Basic Service Report dated April 21, 2008, and Oswestry questionnaire dated May 12, 2008. It was unfortunate that Dr. did not have these assessments available to him at the time of his review. Dr. recites ODG guidelines Pain Chapter Pain Management Programs and gives a list of negative predictors. This preauthorization is for a functional restoration program and not chronic pain management. The patient does not possess a negative relationship with employer, dissatisfaction with his job, or a negative outlook about future employment. This is quite the opposite as the patient is looking forward to returning to work as soon as possible. At admission into the OPMR program, the patient did report elevated levels of depression, pain, and disability. His initial FCE placed him in the sedentary PDL and his mid-term FCE on May 12, 2008, following the initial eight unit of OPMR placed him in the medium PDL with every indication he could be returned to light duty work if he had a job to return to. He does not smoke and does not have any prevalence of opioid use nor is there any evidence of substance abuse. As a matter of fact, he was only taking one Vicodin pill a day before the therapy session. Our request for TPIs was withdrawn at his request on May 20, 2008, as he feels he does not need them and does not want the spinal surgery other doctors were recommending. The patient does not have chronic pain syndrome. He was suffering from a significant loss of ability to function independently resulting in chronic pain due to the complete lack of inactivity and total deconditioning. He was told by several doctors he had to have surgery in order to regain normal function. Without the use of excessive narcotics, muscle relaxants, psychotherapeutic drugs, or the requested trigger point injections one month ago, he was able to regain almost*

*50% of his premorbid strength and endurance levels needed to return to a high paying job that he was happy and content with. The patient and Dr. do not believe he is a true surgical candidate. The patient has exhibited increase in endurance, strength, improved attitude, decreased depression, and improved motivation with patient education and vocational counseling, and has demonstrated observed increases in activities of daily living (ADLs). There are no negative predictors to indicate that the patient will not reach stated discharge goals of regaining at least 90% of premorbidity functionality, strength, and work tolerance for 10-12 hours shifts. He has responded as expected to OPMR. Our*

objective findings showed improvement in overall general functionality. If he is able to complete the additional requested treatment, he should be able to regain most, if not all, premorbid strength, endurance, and stamina needed to return to his previous 10-12 hour workday. The patient has been compliant, punctual, and is highly motivated to return to work. He continues to perform self-directed HEP. He feels that by continuing the program, he will not need to have invasive spinal surgery that cannot be reversed, if it is unsuccessful. He does not have a job to return to at. Case management attempts to coordinate this program between this office, the adjuster, and the human resources were not successful. Since there is no job to return to, ODG guidelines expressly state work hardening is only recommended when there is an employer or employee defined return to work goal agreement.

On June 2, 2008, a letter was returned to Dr. by and. It stated: We have a referral from your office dated March 31, 2008, for evaluation and treatment of this patient as an outpatient in an OPMR program, and ordered for an FCE and EMG/NCV. We have also made several attempts to conduct a team conference with you, to show you the progress the patient has made in the program. When he first presented, he had trouble rising from a seated position. Today he is able to walk for more than 40 minutes on a treadmill at over three miles per hour and able to leg press 180 pounds 10 x 3 repetitions without the onset of low back or leg pain. He does not complain of any radiating leg pain. Our request for TPIs was also withdrawn due to the improvements and quality of the patient's pain complaints. Through McKenzie exercises and other modalities, his pain has now focussed exquisitely to the right SI joint. Any doctor of occupational medicine would concur that the patient should be returned to modified light duty, but the patient has no job to return to at. Therefore, completion of the proposed OPMR is necessary for him to be employable. His midterm FCE places him in the medium PDL work category. If he is able to complete rehab, we feel he will be able to return to full duty by June 30, 2008. Our original prognosis was June 15, 2008, but his progress has been interrupted with these denials. You have not seen this patient in over six months, that being on December 6, 2007. You have refused to see him for a follow-up we requested over a month ago and a treating doctor is required to see his patient at least every 30 days. The patient has made impressive objective and clinically measured gains and you have not been available to him to see his progress. He is very confident that he may not need surgery and like any reasonable individual would avoid and only undergo spine surgery as a last resort. The patient has requested a change of treating doctor and based solely on the aforementioned, Dr. has reluctantly agreed. He needs to complete functional restoration to be employable. In the absence of the previous surgical indications and knowing that he is entitled to life time medical, his current personal situation dictates return to work since his wife, that has been supporting their family single handedly, is pregnant and is now carrying his fifth child. Our plan of care all along had been to have the patient complete the rehab program and return to work. If he is unable to perform, then a second request for a spine surgery could be submitted and a six-month extension to extend the statutory MMI could be submitted well before September 29, 2008.

On May 22, 2008, an appeal for lumbar TPIs was non-authorized.

On June 12, 2008, Dr. stated: Our request to complete the proposed OPMR was denied. An appeal was filed and the treating doctor performed the second

peer review stating he did not order OPMR. The patient has been abandoned by his treating doctor and has refused any treatment. A change of treating doctor was filed by the patient on June 2, 2008. Reasons to approve the requested treatments: (1) The patient has progressed from sedentary PDL to medium PDL after attending 10 of 20 requested sessions of OPMR. (2) He does not exhibit radiculopathy as previously diagnosed. (3) He has pain localized in the right SI joint only and is absent of bilateral pain in the lumbar region as previously noted. (4) He does not have a modified light duty job to return to. (5) The program elements and goals outlined in the request for 80 additional units of OPMR are consistent with the ODG setting. The initial request was to bring the patient to premorbid work capabilities. Dr. ignored the request for OPMR and denied the request as being request for CPMP, which was not the case. The patient does not need behavioral modification or psychological reprogramming. Dr. s refusal to see the patient has forced the patient to file for a change of treating doctor in order that he may attempt to complete the proposed functional restoration program so he may become employable and return to the same job he left because he should be able to perform as a once he has regain premorbid strength and endurance levels.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE**  
**CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT**  
**THE**  
**DECISION. I DO NOT CONSIDER THIS A CPMP, BUT ANOTHER TERM FOR**  
**WORK HARDENING OR COMPREHENSIVE THERAPY. USING WORK**  
**HARDENING AS THE CRITERIA AND NOT CPMP THE PATIENT HAS**  
**DEMONSTRATED SIGNFICANT IMPROVEMENT WITH THE FIRST TEN**  
**SESSIONS THEREFORE, ODG CRITERIA IS BEING MET. THE ONLY**  
**QUESTION IS TO WHETHER THE PATIENT HAS A JOB TO RETURN TO,**  
**BUT THAT WAS NOT ADDRESSED IN THE RECORDS RECEIVED.**  
**HOWEVER, WITH DOCUMENTED IMPROVEMENT BASED ON ODG WORK**  
**HARDENING GUIDELINES THE ADDITIONAL TEN SESSIONS (EIGHTY**  
**UNITS) IS WITHIN RECOMMENDATIONS AND SHOULD BE APPROVED.**

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT  
GUIDELINES