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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 08/17/2010

IRO CASE #:

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

This case was reviewed by a Pain Management (Board Certified) Doctor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening/Work Conditioning; initial 2 weeks, 10 sessions/80 hours

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Submitted medical records were reviewed in their entirety.
- Treatment guidelines were provided to the IRO.
- 07-23-08 Lumbar x-rays read by Dr.
- 08-26-08 Medical Evaluation report EMG/NCV from Dr.
- 10-01-08 Lumbar MRI read by Dr.
- 11-11-08 Electrodiagnostic study read y Dr.
- 01-21-09 Initial Medical Report from Direct Medical, unsigned
- 03-28-09 Medical report from Dr.
- 04-09-09 Lumbar MRI read by Dr.
- 05-26-09 Procedure report for LESI from Dr.
- 10-16-09 Operative Report from Dr.
- 11-30-09 Therapy visit notes from Dr..
- 06-01-09 Through 12-11-10 treatment notes from JS and DS (?) 22 DOS
- 02-16-10 Follow-up Consultation report from Dr.
- 02-17-10 Initial Evaluation from Dr.
- 03-10-10 Follow-up Evaluation from Dr.
- 04-05-10 plus 05-06-10 and 06-07-10 SOAP notes, Direct Medical, unsigned
- 04-07-10 Follow-up Evaluation from Dr.
- 05-05-10 Follow-up Evaluation from Dr.
- 05-14-10 Balance studies from unsigned -
- 05-18-10 Physical Performance Evaluation from Direct Medical, unsigned
- 06-07-10 Letter regarding a possible sales position from an employer -
- 06-14-10 Functional Capacity Evaluation, unsigned from Direct Medical HC
- 06-17-10 Request for pre-authorization WH sessions from Dr., DC
- 06-22-10 Psychological Diagnostic Interview re-evaluation from Dr..
- 07-01-10 Interventional Pain Specialist medical report from Dr.
- 07-16-10 Fax request for reconsideration, work hardening, unsigned

- o 07-02-10 Review for work hardening from MRI
- o 07-02-10 Adverse Determination letter from
- o 07-20-10 Review for reconsideration work hardening from MRI
- o 07-20-10 Adverse Determination letter for reconsideration from
- o 07-20-10 Request for IRO from the Claimant
- o 07-29-10 Confirmation of Receipt of Request for IRO from TDI
- o 07-30-10 Notice to P&S of Case Assignment from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back on xx/xx/xx. She was seen in an ER and provided medication and injection, returned to light duty and ordered PT. Lumbar x-rays were unremarkable. She was given a diagnosis of lumbago.

Electrodiagnostic studies performed August 26, 2008 showed left L5 and S1 radiculopathy.

Lumbar MRI performed October 1, 2008 was given impression: Lumbar disc protrusion centrally at L4-5 and to a lesser degrees, L5-S1. The vertebral bodies and disc heights and signals were all normal.

Electrodiagnostic studies performed November 11, 2008 showed evidence of mild to moderate acute L5-S1 radiculopathy on the left.

The initial examination of January 29, 2009 noted severe low back pain in a -year-old female since. There is no light duty for her. She attended PT. MRI showed central disc protrusions L4-5 and L5-S1. Nerve studies showed mild L5-S1 radiculopathy. She would undergo conservative treatment.

The patient was seen in orthopedics on March 26, 2009. Although the MRI report was read as normal, the provider interpreted a left sided disc herniation at L4-5. The nerve studies showed a left L5-S1 radiculopathy.

MRI performed April 9. 2009 was given impression, broad-based disc protrusion at L4-5. The neural foramen were patent at L4-5 and L5-S1.

The patient was administered a lumbar epidural injection on May 25, 2009.

EMG/NCV performed August 26, 2009 revealed mild to moderate L5-S1 radiculopathy.

On October 16, 2009 the patient underwent left L4-5 laminotomy and discectomy for a disc herniation on the left.

Treatment notes covering 12/07/09 through 01/11/10 have been submitted covering 22 visits. The records reflect no significant improvement in low back and left leg radicular complaints. Pain levels vary from 4-8/10 and the pain is described as aching and stabbing and occasional as burning. Treatment includes joint mobilization, myofascial release and therapeutic exercises. The treatment plan consistently states, continue treatment plan. There is no indication of objective findings or functional improvements.

On February 16, 2010 the patient is reporting low back and left buttock pain. She is attending PT.

A pain management evaluation was provided on February 17, 2010. About two months after the surgery she developed low back and left sided leg pain. Sensation is abnormal; motor strength is grossly intact. She is a good candidate for LESI x 2. She is currently on a chronic pain management program. She should continue with the CPMP.

On March 10, 2010 the pain management provider noted impression of post discectomy or laminectomy syndrome, lumbar nerve root irritation, lumbar discogenic pain and myofascial pain and spasms. She is awaiting epidural injections.

Additional SOAP notes covering three visits dated 04/05/10, 05/06/10 and 06/07/10 note continued low back and left leg pain. Objective findings include restricted range of motion, positive orthopedics tests. On May 6, 2010 she reports reaction to the last epidural injection of headaches. She is approved for an additional injection but declines. She wants to continue with the chronic pain management program (CPMP). A note on the June 7, 2010 records states currently on second set of chronic pain management (CPM). Plan is to finish CPMP.

Examination of May 5, 2010 noted insomnia, mood swings and fatigue and malaise. She has lower back spasms. Left straight leg raise is positive more than right and motor weakness is noted on the left. Medictions of Lorcet, Zanaflex and Mobic are refilled. She is planned to undergo an epidural injection.

Balance studies were performed on May 15, 2010 and showed the patient has evidence of significant peripheral vestibular dysfunction and central vestibular dysfunction. Recommendation was for balance rehabilitation and special imaging.

Physical Performance Evaluation dated May 18, 2010 noted the patient is able to lift 10 pounds and push 26, pounds. Her job is a Medium PDL and she is currently at a frequent Sedentary PDL and occasional Light PDL. She showed valid efforts.

Per psychological evaluation of May 22, 2010 the patient has a BDI of 33 indicating severe depression and a BAD index of 24, which indicates moderate anxiety. The fear index questionnaire indicates the patient feels she will not be at work in 3 months.

FCE dated June 14, 2010 notes the patient as 5' 5" and 155 pounds. She can lift 10 pounds and push 26, pounds. Her housekeeper job is a Medium PDL and she is currently at a frequent Sedentary PDL and occasional Light PDL. She showed valid efforts.

On June 17, 2010 the provider requested 10 sessions (80 hours) of the Work Hardening Program for the period of 06/30/2010 to 08/16/2010. The request included attachments of physiological evaluation, Job Description Form, FCEs of 06/14/10 and 05/18/10 and medical reports/diagnostic studies. A letter from an employer noting a possible position for the patient if she is physically capable is submitted. Per the provider, the patient meets the criteria for the requested program based on described criteria.

The patient underwent a psychological interview on June 22, 2010. She has walking and sitting limitations. She has gained 10 pounds. She is using Lorcet and Flexeril. She reports an average pain level of 7/10. She has
completed 20 sessions of an interdisciplinary chronic pain management program with good results. She would like to return to work but has not been able due her pain. She does have a job to return to. Testing has shown a Beck Depression Index (BDI) of 27 on 01/14/10, 23 on 02/15/10 and 33 on 06/09/10 (moderate to severe depression). Her BAI index was 20 on 01/14/10, 17 on 02/15/10 and 24 on 06/09/10 (moderate anxiety). Her Oswestry Disability Index scores place her in the severely disabled range. Her fear avoidance questionnaire showed 24/24 indicating a high level of fear and avoidance beliefs. Her psychological scores have slightly worsened after completing the CPMP. She is recommended to attend a trial of 10 sessions of an interdisciplinary work hardening program, 8 hours a day, 5 days a week for 2 weeks.

An Initial pain management evaluation was provided on July 1, 2010 for lower back, left leg and left foot pain. Her treatment has included heat, cold, prescription medications, PT, home exercises, injections and a surgery in October 2009. She describes a pain level of 7-9/10 [Pages 2-3 are lacking]. The patient was subsequently authorized to attend a chronic pain management program

Request for Work Hardening/Work Conditioning; initial 2 weeks, 10 sessions/80 hours was considered in review on July 2, 2010 with recommendation for non-certification. Per the reviewer, the claimant is not a candidate for a work hardening program. The psychosocial deficits are beyond the limits of this particular return to work program. In additional, the serial use of upper level therapeutics like chronic pain management and work conditioning is not advisable and unnecessary. The provider has not established any rationale to warrant the use of a 10-session course of work hardening in the management of this patient's condition. She was recently authorized a chronic pain management program. The successive use of these programs is not medically necessary.

Request for reconsideration Work Hardening/Work Conditioning; initial 2 weeks, 10 sessions/80 hours was considered in review on July 20, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. The information submitted for review indicates the patient has completed a chronic pain management program for the lumbar condition. Treatment notes covering 12/07/09 through 01/11/10 have been submitted. The records reflect no significant improvement in low back and left leg radicular complaints. Treatment includes joint mobilization, myofascial release and therapeutic exercises. The treatment plan consistently states, continue treatment plan. There are additional SOAP notes 04/05/10, 05/06/10 and 06/07/10 which note continued low back and left leg pain. Objective findings include restricted ranges of motion, reflex findings, and orthopedic test findings. Assessment is V45.89, 724.4 and 729.1. The 04-05-10 record notes the patient is pending more CPMP. The 05-06-10 record notes the patient has an adverse reaction to her last ESI procedure, and that she does not want to continue with ESI, but wants to continue with the chronic pain management program (CPMP). The 06-07-10 records notes report low back pain and radicular pain improved with treatment. Plan is for the patient to finish CPMP. There is a 07-10-10 interventional Pain specialist initial evaluation, which notes the patient underwent back surgery on October 2009. Per ODG criteria for admission to a work hardening program: Repetition: Upon completion of a rehabilitation program (e.g work conditioning, work hardening, outpatient medical rehabilitation or chronic pain functional restoration program), neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

Request was made for an IRO.

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

ODG criteria for admission to a work hardening program includes: 21) Repetition: Upon completion of a rehabilitation program

(e.g work conditioning, work hardening, outpatient medical rehabilitation or chronic pain functional restoration program), neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

The patient was seen for severe low back pain. Nerve studies showed some L5-S1 radiculopathy on the left. Although imaging did not show a neurocompressive lesion, a surgery was performed. Several months following the surgery the patient's back and leg pain returned, worse than prior to her surgery. She attended PT. Motor strength remained good but some sensation abnormality was noted. On February 17, 2010 the pain management provider noted that she is currently attending a chronic pain management program. She should continue with the CPMP. On May 6, 2010 she was approved for an additional epidural injection but declined. She wanted to continue with the chronic pain management program (CPMP). A note on the June 7, 2010 records states currently on second set of the chronic pain management (CPM). The plan was to finish the CPMP. Balance studies of May 15, 2010 showed significant peripheral vestibular and central vestibular dysfunction. Recommendation was for balance rehabilitation and special imaging. FCE noted that her job is a Medium PDL and she is currently at a frequent Sedentary PDL and occasional Light PDL. The psychological interview of June 22, 2010 noted, she has completed 20 sessions of an interdisciplinary chronic pain management program with good results.

First line review rationale for non-certification noted the psychosocial deficits are beyond the limits of this particular return to work program. In additional, the serial use of upper level therapeutics like chronic pain management and work conditioning is not advisable and unnecessary. The provider has not established any rationale to warrant the use of a 10-session course of work hardening in the management of this patient's condition. She was recently authorized a chronic pain management program. The successive use of these programs is not medically necessary.

Second line review rationale for non-certification noted ODG criteria for admission to a work hardening program: Repetition: Upon completion of a rehabilitation program (e.g work conditioning, work hardening, outpatient medical rehabilitation or chronic pain functional restoration program), neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The patient had already attended a 20 sessions CPMP.

The patient attended 20 sessions of a chronic pain management program. According to the psychologist, her psychological scores have slightly worsened since completing the CPMP. She remains severely depressed and moderately anxious. The prior rationale that the psychosocial deficits are beyond the limits of this particular return to work program, continues to have merit. The patient is severely depressed and has significant balance issues with additional treatment recommended. More importantly, ODG does not support reenrollment is a same or similar rehabilitation program. Given the patient's prior completion of 20 sessions of a CPMP, she is not a candidate for full day sessions of work hardening.

Therefore, my recommendation is to agree with the previous non-certification for Work Hardening/Work Conditioning; initial 2 weeks, 10 sessions/80 hours

The IRO's decision is consistent with the following guidelines:

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
__X___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

The Official Disability Guidelines 08-05-2010 Low Back Chapter - Work Hardening/Work Conditioning:

Criteria for admission to a Work Hardening (WH) Program:
(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been

provided.
(2) Screening Documentation: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.
(3) Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).
(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.
(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.
(6) Rule out surgery: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).
(7) Healing: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
(8) Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.
(9) RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.
(10) Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.
(11) Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.
(12) Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.
(13) Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.
(14) Trial: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.
(15) Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.
(16) Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.
(17) Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.
(18) Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).
(19) Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of

weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.
(20) Discharge documentation: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.
(21) Repetition: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Work Conditioning (WC) Physical Therapy Guidelines
WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. W C visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, W ork Conditioning participation does not preclude concurrently being at work.
Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.