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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 07/16/2010

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 conditioning 4 hours a day x 5 days a week x 2 weeks (40 hours) 97545/97546

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

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
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PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an injury to the low back on xxxxxwhen her

rolling chair flipped and she fell to the floor. She landed on her buttocks and sacral area and her back and head hit the floor. She is followed with a diagnosis of lumbar sprain.

Initial examination notes indicate existing health conditions of hypothyroidism, hypertension, high cholesterol, anxiety, depression, GERD, sleep apnea, urinary incontinence, and migraine headaches. The patient is 5 feet and 246 pounds. She has a back sprain with myospasm.

The patient was assessed in PT on xxxx. She reports low back pain of 8/10. She can flex to 30 degrees and extend to 13 degrees. Diffuse strength deficits are noted. Sensation is normal. She has good rehab potential for her sprain injury.

12 PT progress notes between April 16, 2009 and May 13, 2009 indicate treatment provided only. There are no notes indicating the patient's response to treatment.

Lumbar MRI was performed on April 27, 2009 reportedly shows multilevel lumbar spondylotic changes, moderate-to-severe left foraminal narrowing at L5-S1, mild spinal canal stenosis at L4-5. Thoracic MRI reportedly shows left central to left subarticular disc herniation extrusion type at T5-6 and subarticular right disc herniation protrusion at T6-7, T7-8, and T8-9. There is mild-to-moderate spinal canal stenosis at T4-5 and mild spinal canal stenosis at T5-6 and T8-9. There is moderate right foraminal narrowing at T8-9 and moderate left foraminal narrowing at T5-6. Gabapentin was "initiated." Aqua therapy is indicated, however, she has already attended 3 weeks of PT without benefit. Recommendation is for EMG to see if she is a candidate for epidural injections.

Provider progress notes of June 15, 2009 notes back pain that radiates down the back of both legs with numbness. On June 27, 2009 she is waiting to see a specialist. On June 29, 2010 she can work with restrictions. Her back pain is not improving. Some of the notes are illegible.

Orthopedic evaluation of July 7, 2009 notes occasional radiation of back pain to the lower extremities. She did some PT for a while, but then it was discontinued. She is using Depakote, Imitrex, Flexeril, Lortab, Celexa, Protonix, Napreian, Benclar, levothyroxine and Buspar. She does not smoke. She is not in distress. She has tenderness but a normal neurologic examination. MRIs have not shown any disc herniations. Recommendation is for additional PT and a pain management consultation.

Provider notes of August 14, 2009 note the patient is referred to pain management for epidurals.

The patient was evaluated in pain management on September 21, 2009. Her pain varies from 1-10/10. She occasionally has difficulty getting out of bed. She describes a spasmodic type pain. TENS unit is helpful and she should continue this modality. Lumbar flexion and extension are painful. Kemp's test is negative.

Orthopedic reevaluation was provided on September 21, 2009. She does not have any acute deficits compared to the previous evaluation. Diagnosis is lumbosacral spondylosis with myelopathy.

The patient returned to pain management on October 19, 2009. She reports a pain level of 4-8/10. Request for EMG was denied. She is working full time with restrictions. EMG is reordered. Recommendation is for bilateral ESI at T8-9.

Handwritten medical notes are reviewed covering eight visits during the period of March 1, 2010 through May 24, 2010. Many of the notes are illegible. She complains of increased back pain (04-02-10). She has been trying to work with restrictions but reports increasing pain (04-09-10). There is no guarding with movement on examination (05-10-10). Weight reduction was recommended. She is referred to PT to assess for work conditioning. She is not returned to work and has applied for disability (05-24-10).

The patient was reevaluated in pain management on May 17, 2010. She reports persisting severe symptoms and sleep difficulty. She reports a pain level of 8-10/10. Straight leg raise is positive at L4-5 and L5-S1. Slump's test is positive at L4-5 and L5-S1 4/5. She will be put on Kadian 20 mg twice daily and continue hydrocodone. She will initiate Lunesta 2 mg.

FCE was performed on May 19, 2010. She has the following limitations: Decreased lumbar active ROM. Decreased bilateral lower extremity manual muscle strength. Inadequate strength levels per DOT-PDC's. Decreased static squatting ability. Decreased kneeling ability. She is currently unable to return to work as an RN. She would benefit from a work-conditioning program. She can lift 32 pounds floor to knuckles and carry 16 pounds for 6 feet. She is 5 feet and 246 pounds. Blood pressure is within normal. Her work requires a Medium PDL. She is currently functioning at a Lower Medium PDL. Lower extremity manual strength is 4-5. She demonstrates antalgic gait. She is unable to kneel. Grip strength is 24 pounds right and left. Heart rates showed good efforts. She has minimal depression.

The patient was most recently reevaluated by her orthopedic provider on June 15, 2010. She is doing well in terms of pain, but Lunesta caused quite a bit of side effects, with bad taste in her mouth the following morning. She would like to try something else. She reports a pain level of 3-6/10. She has chronic pain, stomach ulcers, urinary incontinence, morbid obesity, hypothyroidism and hyperlipidemia. Cervical and thoracic examination are unremarkable. Lumbar flexion and extension elicit pain. Her Kadian is refilled. She will discontinue Lunesta and initiate Ambien. She will continue gabapentin.

Request for work conditioning 4 hours a day x 5 days a week x 2 weeks (40 hours) was considered in review on June 1, 2010 with recommendation for non-certification. 29 pages of medical records were reviewed. The rationale for denial notes no documentation of a course of PT. Guidelines support 10 visits of PT for the patient's diagnosis. Work conditioning amounts to an additional series of intensive physical therapy visits required beyond a normal course of physical therapy, primarily for exercise training/supervision. The clinical note dated 5/24/10 reports the patient has been referred to PT to evaluate and treat; however,

documentation of the prescribed PT has not been provided. The patient is 5 feet and 258 pounds (BMI 50.38). Additionally, the request is submitted is for a total of 40 hours of work conditioning, which exceeds the recommended guidelines timeline of no more than 30 hours.

Request for reconsideration work conditioning 4 hours a day x 5 days a week x 2 weeks was considered in review on June 14, 2010 with recommendation for non-certification. 49 pages of records were reviewed, some containing illegible notes. FCE showed Lower Medium PDL. Lumbar x-rays of 4/10/09 showed moderate multilevel lumbar spondylosis without evidence of acute bone injury or disease. MRI of 4/27/09 showed moderate to severe left foraminal narrowing at L5-S1 and mild spinal canal stenosis at L4-5 and L5-S1. She has attended 19 sessions of PT (illegible report dated 5/11/09), goals not met. A peer discussion was attempted but not realized. Rationale for denial states, the criteria for Work Conditioning as recommended by evidence-based guidelines cited were not fulfilled. The FCE indicated a Lower Medium strength level while her job as a Registered Nurse requires a Medium PDL. There is no documentation that there were unsuccessful attempts of the patient to return to work. The current examination shows an unremarkable cervical and thoracic examination. She has chronic pain, stomach ulcers, urinary incontinence, morbid obesity, hypothyroidism and hyperlipidemia.

Request was made for an IRO.

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

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). WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work. Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

There should be a screening evaluation and 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. There should be 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. There should be evidence that there are no 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 and a specific defined return-to-work goal or job plan has been established. Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance.

The patient is an RN with a number of pre-existing comorbid health conditions. 12 PT progress notes between April 16, 2009 and May 13, 2009 indicate treatment provided only without indication of the patient's response to the treatment. She has pre-existing thoracic stenosis per imaging. Given the lack of acute deficits and a normal neurologic examination, the diagnosis of lumbosacral spondylosis with myelopathy is not supported. She was referred to pain management for epidurals but there are no neural deficits documented. In April she was working with restrictions but reported increased pain and appears to have been kept off work since about that time. In May 2010 she is put on Kadian 20 mg twice daily and Lunesta 2 mg and will continue hydrocodone. FCE showed ROM and strength deficits, although the patient's body habitus would make ROM and lifting/carrying /pushing activities difficult. Her work requires a Medium PDL; she is currently functioning at a Lower Medium PDL.

First level rationale for denial notes no documentation of PT and, the request is submitted is for a total of 40 hours of work conditioning, which exceeds the recommended guidelines timeline of no more than 30 hours.

Second level rationale for denial notes she has attended 19 sessions of PT [12 appears to be more accurate] with no goals met and there is no documentation that there were unsuccessful attempts by the patient to return to work.

The patient attended at least 12 sessions of PT over three weeks with no significant benefit. Work conditioning visits per guidelines, will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. The patient's comorbid conditions cannot be brushed aside. Per guidelines, there should be evidence that there are no 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 and a specific defined return-to-work goal or job plan has been established. Additionally, 30 hours are supported at maximum, with a trial of two weeks. Overall, it does not appear that the patient's long-term outcome would be altered by attending work conditioning at this time.

Therefore, my recommendation is to agree with the previous non-certification of the request for work conditioning 4 hours a day x 5 days a week x 2 weeks (40 hours) 97545/97546.

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
- 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 - Lumbar Chapter (2010) - Work Conditioning/Work Hardening:

Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty RTW program, rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. See also Return to work, where the evidence presented for "real" work is far stronger than the evidence for "simulated" work. Also see Exercise, where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job

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.