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Notice of Independent Review Decision

DATE OF REVIEW: December 21, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

80 hours of work hardening for lumbar spine.

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

The physician providing this review is a Doctor of Chiropractic. The reviewer is certified by the National Board of Chiropractic Examiners.

REVIEW OUTCOME

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

Upheld (Agree)

Medical documentation **does not support** the medical necessity of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported an injury on xx/xx/xx, when he bent down to pick up an object and experienced significant pain in his lower back and right lower extremity. He worked as a and his job required occasionally pushing, pulling and positioning metal molds weighing as much as 2000 – 3000 pounds on ceiling cranes to the work horizontal lathes that required constant bending, stooping and squatting.

2009: M.D., evaluated the patient for low back pain and right radiculopathy. Pain radiation started in the buttock region into the right groin and right lower extremity. The patient was involved in a motor vehicle accident (MVA) while driving in 2006. The symptoms related to the accident had abated over time. There were no symptoms until xx/xx/xx. Examination revealed significant right paraspinous tenderness, significant pain with forward flexion and positive tension sign to 45 degrees on the right. Dr. diagnosed low back pain with right radiculopathy and prescribed Medrol Dosepak and analgesic for intermittent pain along with a muscle relaxant. He obtained a magnetic resonance

imaging (MRI) of the lumbar spine that revealed significant disc pathology throughout the spine and recommended epidural steroid injection (ESI).

D.C., noted MRI of the lumbar spine had shown marked compression of the right S1 nerve root with a focal right paramedian herniation measuring 3.4 mm with endplate and facet joint hypertrophy at the L5-S1 level creating severe right lateral recess stenosis.

2010: From January through April, the patient had lumbar ESI x2 at L5-S1 with 60% reduction in overall pain response with the first injection and no appreciable benefit from the second injection. Dr. referred him for surgical management.

M.D., an orthopedic surgeon, evaluated the patient for back and lower extremity pain. Examination showed slight antalgic gait pattern on the right, reproduction of pain with toe-walk and heel-walk, decreased range of motion (ROM) and decreased sensation in L5-S1 dermatomal distribution on the right compared to the left. The electromyography (EMG) studies showed right S1 radiculopathy. Dr. diagnosed right S1 radiculopathy secondary to herniated nucleus pulposus and performed right L5-S1 laminotomy for decompression, right L5-S1 partial discectomy for decompression on July 6, 2010. The procedure was markedly complicated due to morbid obesity and overall size standing 6'7" and weighing 415 lbs.

Postoperatively, the patient attended 15 sessions of physical therapy (PT) and was utilizing transcutaneous electrical nerve stimulator (TENS) unit. Dr. noted the patient was doing well and recommended work hardening program (WHP).

In November, LPC, noted the Beck Depression Inventory II (BDI-II) score was 19 and Beck Anxiety Inventory (BAI) score was 17. The Fear Avoidance Beliefs Questionnaire (FABQ) was administered where the work scale was 42/42 and anxiety scale was 24/24 and SOAPP-Ft of 8. Ms. assessed adjustment disorder with mixed anxiety and depressed mood and pain disorder with both psychological factors and a general medical condition. The evaluator recommended WHP in order to facilitate reconditioning and return to work. In a functional capacity evaluation (FCE), the patient qualified at a light physical demand level (PDL) and his disability was 52% consistent with severe disability.

Dr. stated the patient's job required PDL that was heavy to very heavy and therefor recommended WHP.

Per utilization review, the request for 80 hours of WHP for lumbar spine was denied with following rationale: *"is a man who reportedly was injured on xx/xx/xx. He had an unknown number of PT sessions at Injury Center of and then underwent unilateral L5-S1 right-sided laminotomy and discectomy for decompression on July 6, 2010. This was followed by 16 sessions of postop PT at Injury Center. According to the records from Injury Center these sessions consisted of manual therapy and 45 minutes of exercise. On November 12, 2010, D.C., who has the same address and phone number as Injury Center reported that Dr. of Injury Canter referred the employee to his facility far a WH program. He reported that present pain level is 7/10. FCE dated November 5, 2010, revealed the employee to be functioning at a Light PDL. Dr. reported that employee's occupation requires a Heavy PDL. There is a form from ER that was submitted with the request that Indicates a Heavy PDL but this is*

contradicted by a form from ER dated June 1, 2010, that indicates that the required return to work (RTW) PDL is actually medium. There is no confirmation of ER-employee agreement on RTW goals. Per the FCE current Oswestry score is 52%. Psych evaluation at dated November 5, 2010, reported BDI of 19, BAI Of 17, FABQ-PA of 24/24. FABQ-W Of 42/42 and SOAPP-Ft of 8. I called Dr. on 11/16/10 at 11:45 A.M. CST. He came to the phone and spoke at length about the case. He described the WH program at length. He stated that the postop PT was performed at his facility. I recommend non-certification of the request for the following reasons:

1 The ODG TWC 2010 Low Back chapter requires "evidence of treatment with an adequate trial of active physical rehabilitation with Improvement followed by plateau". In this case, has had extensive PT at the requesting facility and yet is only functioning at a Light PDL with high pain levels, severe perceived disability and extremely high fear-avoidance beliefs. Thus, there is no evidence of improvement with PT.

2 The ODG TWC 2010 Low Back chapter requires "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". In this case there is contradictory Information regarding ER's assessment of the required PDL for RTW FD and no clear evidence of agreement on RTW goals."

Dr. appealed for WHP program and stated that admission into a WHP had been established as medically necessary based on the following facts:

- 1) Mr. met both the Official Disability Guidelines (ODG), 2009 and DWC Medical Fee guidelines entrance criteria for work hardening (pg. 37-33).
- 2) Functional deficit had been proven per an objective and valid evaluation on November 5, 2010.
- 3) Psychological assessment had determined WH rather than Work Conditioning as necessary.
- 4) A highly structured work hardening program had been recommended by the patient's treating physician, D.C.
- 5) Medical probability indicated the patient had a good prognosis of returning to work upon completion of the program.

Per reconsideration review dated November 30, 2010, the appeal for 80 hours of WHP for lumbar spine was denied with following rationale: "The current clinical Information reveals that the patient is and status post work related low back Injury as of xx/xx/xx, as a result of repetitive lifting. The patient is reported to have undergone L5-S1 laminectomy, discectomy July 6, 2010. The patient has completed 16 visits of post operative PT. The patient is reported to have had an FCE November 5, 2010, which reveals the patient is capable of light duty. There is no evidence of a therapeutic plateau following the Initial course of post operative PT. Due to the lack of a therapeutic plateau, the request for work hardening is not supported as necessary."

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

Based on my review of the records, the injured employee is described as a 6'7" tall male weighing 415 pounds with a BMI of 46 placing him in the morbid obesity category. He is reported to have congenitally small spinal canal at L4 through

S1. Objective diagnostics reported him to have a disc disorder in the lumbar spine and right S1 radiculopathy. He was initially treated with chiropractic manipulation, physical therapy, medications, and epidural steroid injections without any remarkable lasting benefit so he was sent for surgery. Surgery consisted of right L5/S1 laminotomy, partial L5/S1 discectomy, and was complicated by the patient's morbid obesity. Despite all of these therapies and procedures, the claimant reported severe disability and severe pain currently. Therefore, I found no evidence in the records of any remarkable benefit from the therapy and procedures provided that would support the probability of success with a work hardening program as suggested by the chiropractor. Based on ODG, there must be some therapeutic benefit from medical interventions and therapeutic approaches to support the transition to an intensive work hardening program. Currently, the claimant is reporting severe disability and severe pain and would unlikely succeed with the planned approach.

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

- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**

- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES – INTERNET BASED**