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Notice of Independent Review Decision

DATE OF REVIEW: June 21, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work Hardening 80 Hours for the Lumbar Spine. CPT Codes: 97545 and 97546.

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

REVIEW OUTCOME
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Medical records from the Carrier include:
- Insurance Company, 06/09/11
- M.D., 02/27/09
- D.O., 06/08/10
- Agency, 01/20/10, 01/22/10

Medical records from the URA include:
- Official Disability Guidelines, 2008
- Agency, 06/08/11
- Provider, 10/01/10, 10/10/10, 11/16/10, 11/17/10, 12/20/10, 02/01/11, 05/10/11, 05/19/11
- Insurance Company, 08/11/08
- Provider, 08/09/08
- M.D., 02/27/09
- Clinic, 05/13/09, 06/29/09
- M.A., LPC, 09/10/10, 11/12/10, 04/29/11
- Clinic, 09/22/10, 11/12/10, 04/26/11
- Clinic, 12/17/10, 01/19/11, 01/31/11, 05/19/11

Medical records from the Provider include:
- Clinic, 05/10/11, 05/14/11,
- Clinic, 04/26/11,
- M.A., LPC, 04/29/11,
- Clinic, 05/19/11, 06/09/11,

PATIENT CLINICAL HISTORY:

The original mechanism of injury is described as a slip and fall injury on XX/XX/XXXX; this is more than X years prior. The patient was performing in his usual capacity for employer when he stepped on a piece of wood, lost his balance, and fell backwards. The fall resulted in diffuse, nonspecific pain of the totality of his back. The pain self assessment on April 29, 2011, was 6/10 on the visual analog scale. It is noted the patient was fired from his position shortly after his injury. His medications at the time of presentation included Flexeril, Elavil, and Hydrocodone. There was no prior history described, which would impact upon his current condition. There was a work hardening program recommended by M.A., for functional rehabilitation.

It is noted that the request for work hardening was denied as neither reasonable nor necessary. D.C., reported that this was essential to help integrate him back into his previous job.

There was a peer review performed by D.C., on August 9, 20XX, who noted that there was a X-month interval between the alleged time of injury and the initiation of medical care. The reason for this delay is not indicated. However, this would seem to indicate that causality would seem very nebulous. It was Dr.'s opinion that the effects of the compensable injury had resolved. It is noted that the ODG for low back injuries states that 85% of the time sprains will resolve within six weeks of injury. It also states that returning to work is actually therapeutic and beneficial for these types of injuries.

In the additional medical documentation, the patient underwent, what appears to be, an impairment rating by M.D., on February 27, 2009. Dr. did not feel this patient had any basis of permanent impairment and awarded him a 0% impairment for his injuries. Dr. reviews imaging studies performed on July 12, 2008, which revealed desiccation of the lower two lumbar discs, with a bulge at L4 impinging upon the anterior margin of the thecal sac. There was mild narrowing of the interspace at L5-S1 and minimal anterior slipping of L4 on L5 of approximately 2 mm. The patient was not seen to have any atrophy. His reflexes were 2 and symmetrical. His strength was 5/5 throughout all assessed muscles of the lower extremities. Therefore, there did not appear to be any significant neurological sequela. The assessment was lumbar strain.

There was a functional capacity evaluation performed on May 13, 2009, earlier in the course of the patient's illness. This indicated his function at that point was in the sedentary level for frequent activity and with an occasional light physical demand level activity, which would be well below his previous job requirement of very heavy. It is further noted that he had 5 out of 5 Waddell's signs, potentially indicating the presence of non-organic symptomatology.

There is a preauthorization request from Clinic. This is reported by D.C., on June 29, 2009. The preauthorization request was for work hardening, as Dr. felt this patient meets all of the prerequisites for entry into a work hardening program.

In the medical history reviewed by D.O., it is noted the patient had an electrodiagnostic study which was read as displaying right L5 radiculopathy due to anterior tibialis and peroneus longus fibrillations and sharp waves. There was no latency described. It was Dr. assessment that there was no clinical evidence that this patient had sustained any psychological or psychiatric quantitive assessments which would indicate the necessity of chronic pain management. Based upon his reviewed history, Dr. felt the patient had simply sustained an uncomplicated lumbar strain in the face of degenerative changes. There was no consistent finding on physical examination to corroborate any underlying process. The date of the report is June 8, 2010. Dr. did not feel that any ongoing medications were reasonable or necessary at that point.

I have documentation of requests for work hardening of approximately 80 hours by the medical facility.

There is a functional capacity evaluation from September 22, 2010, revealed the patient to function only within the light physical demand level.

A follow-up functional capacity evaluation from November 12, 2010, less than two months post of previous September 22, 2010, indicated no change in the patient's function. The patient was still at the physical demand level of light, which did not meet his previous physical demand level.

Eighty hours of chronic pain management were requested as of November 16, 2010, by Clinic. This is reported by M.D. This was felt necessary to address the patient's functional deficits, which served as barriers for return to work. This was initially denied, and re-requested as of December 17, 2010.

I have a progress note from Clinic. It is noted the patient had been attending a cognitive pain management session. The patient began attending them on January 4, 2011, and at that point it was two weeks later, and consistent with attendance. There was a request for an additional ten sessions presented.

With regards to chronic pain management programs, the authors note the ODG recommendations "Treatment is not suggested for longer than two weeks without evidence of demonstrated efficacy as documented by subjective and objective gains." This is an ODG recommendation. However, they qualify this by stating that, "It is not suggested that a continuous course of treatment be interrupted at two weeks solely to document these gains if there are preliminary indications." However, the documentation I have indicates there have been no gains. The patient's functional abilities seem to be limited and static.

There is a functional capacity assessment dated April 26, 2011. It is noted the patient's previous job description required a heavy physical demand level, but he was only able to function within a light/medium physical demand level on occasional activities and a light physical demand level on frequent activities. Therefore, this is not a measurable improvement in his overall condition.

There is a behavioral evaluation report from April 29, 2011. This revealed that the patient had exhausted all appropriate levels of care and "previous methods of treating the chronic pain have been unsuccessful." The patient was also seen to be exhibiting pain behavior and functional limitations sabotaging her activities of daily living.

I have no further documentation.

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

I am asked simply if I should uphold or partially overturn the review, and I would uphold the determination. This patient had ten sessions of pain management in January of 2011. There has been no material change in his condition over the X years, X months since his injury. The imaging studies as reviewed revealed degenerative changes, mild spondylolisthesis, and degenerative disc disease with desiccation in the lower two lumbar segments. This patient sustained an uncomplicated soft tissue strain and it was the determination of the designated doctor that the patient had no basis of permanent impairment. As to the etiology of the patient's ongoing pain complaints, I cannot attribute to a single isolated episode. The etiology of the patient's pain complaints, seem disproportionate to the imaging studies. As the Occupational Disease Guidelines stated "continuation of a chronic pain management program is predicated upon objective evidence of

functional improvement," and this is lacking in the medical records. I cannot state that an additional 80 hours of chronic pain management would in any likelihood result in any material change in this patient's condition. As such, I uphold the previous determination.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**