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Notice of Independent Review Decision

Date: December 7, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening program five times per week for two weeks, 8 hours per day

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

Board Certified American Chiropractic Academy of Neurology
Certified American Academy of Disability Evaluating Physicians

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:

- Diagnostics (06/16/10 – 10/31/11)
- FCE (01/11/11 – 07/20/12)
- Office visits (02/28/11 – 11/02/12)
- Therapy evaluation (12/09/11 – 09/14/12)
- Therapy (09/12/12 – 11/05/12)

- Office visits (06/11/10 – 11/02/12)
- Diagnostics (06/16/10 – 10/31/11)
- Bona Fide Job Offer (06/14/10 – 04/29/11)
- Therapy (06/29/10 – 11/05/12)
- Peer review (08/10/10)
- DDE (03/17/11 – 10/20/11)
- FCE (01/11/11 – 07/20/12)
- Surgery (05/17/12)
- Utilization reviews (10/15/12 – 11/12/12)

- Office visits (03/09/11 – 11/02/12)
- Diagnostics (06/16/10 – 10/31/11)
- FCE (01/11/11 – 07/20/12)
- PT evaluation (12/09/11 – 09/14/12)

TDI:

- Utilization reviews (10/15/12 – 11/12/12)

ODG has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was picking up three boxes when he felt a sharp pain in his lower back causing him to fall to his knees on xx/xx/xx.

2010: On June 11, 2010, the patient was evaluated for constant and sharp low back pain radiating to the left leg and toe. Examination revealed positive Yeoman's, Kemp's, Valsalva and straight leg raising (SLR). Range of motion (ROM) was decreased. The evaluator diagnosed low back pain and sciatica, ordered computerized tomography (CT) scan of the lumbar spine and recommended therapy.

On June 16, 2010, CT scan of the lumbar spine revealed mild facet arthropathy at L4-L5 with posterolateral ligamentous hypertrophy, concentric disc bulging producing marginal canal stenosis and possibly mild neural foraminal narrowing. There was facet arthropathy at L3-L4 and L5-S1.

On June 25, 2010, the patient was evaluated for low back injury. assessed local injury affecting low back, lifting injury, painful lumbar radiculitis, muscle spasm of the lower back and sciatica with disc disease. She prescribed Norco and Robaxin and recommended physical therapy (PT). On follow-up, prescribed Naprosyn.

From June through August, the patient attended nine sessions of PT consisting of manual therapy, therapeutic activities, neuromuscular re-education, therapeutic exercises and electrical stimulation.

On August 10, 2010, performed a peer review and rendered the following opinions: (1) In reasonable medical probability there was no injury. (2) There was no identifiable extent of damage or harm to the physical structure. (3) No part of the patient's body was injured and there was no physical, medical or scientific evidence of injury or injury sequelae. (4) The current treatment plan was not reasonable or necessary.

On August 24, 2010, evaluated the patient for constant, moderate and diffuse lower back symptoms which were achy, dull and stiff and sore in quality. Examination revealed positive Kemp's, Deerfield's and Yeoman's tests. treated the patient with therapy consisting of manual therapy and exercises.

2011: On January 5, 2011, noted decreased ROM of the lumbar spine, paresthesias in the L4 and L5 distribution and positive Kemp's, SLR, prone leg raise, psoas, Bragard's, Valsalva and Nachlas tests. He ordered magnetic resonance imaging (MRI) of the lumbar spine and recommended PT.

From January through February, the patient attended three sessions of PT consisting of manual therapy and therapeutic exercises.

In a physical performance evaluation (PPE) performed on January 11, 2011, the patient performed at sedentary to sedentary-to-light physical demand level (PDL) versus medium to heavy PDL required by his job. The evaluator recommended continuing active care program.

On January 18, 2011, evaluated the patient for pain in the lower back associated with weakness, numbness and tingling in the legs. The pain was burning, constant and worse at night. Examination revealed positive facet rocking. diagnosed chronic low back pain, thoracic spine pain and possible lumbar radiculopathy. He prescribed Ultram and Robaxin, ordered electromyography/nerve conduction velocity (EMG/NCV) and recommended PT. On follow-up, recommended advanced supervised exercise program.

On February 21, 2011, EMG/NCV of the lower extremities was unremarkable.

On February 28, 2011, noted sensory deficits in both legs. The patient had denied injections and MRI. prescribed Robaxin, Flexeril and trazodone.

The patient underwent a psychometric testing and was diagnosed with chronic pain disorder associated with both psychological factors and a general medical condition. The evaluator recommended individual psychotherapy.

From March through December, the patient had regular visits and was treated with manual therapy and exercises.

In March, noted improved sleep pattern. He recommended home exercises and follow-up in six weeks. The patient was released to light duty.

On March 17, 2011, performed a designated doctor examination (DDE). She opined that the patient was not at maximum medical improvement (MMI) as he needed an EMG/NCV of the lower extremities and consultation with an orthopedic surgeon.

From April through June, the patient attended four sessions of individual psychotherapy.

On April 11, 2011, noted that EMG had already been performed. She ordered MRI of the lumbar spine to better visualize the lesions.

On April 22, 2012, MRI of the lumbar spine revealed mild disc desiccation at L2-L3 with disc bulging of less than 2 mm concentrically; disc desiccation at L4-L5 with a small annular fissures in the other annular ligament and disc bulging of 3 mm concentrically; disc desiccation at L5-S1 with diffuse disc bulging with superimposed asymmetric protrusion into the left lateral recess and left neural foramen contacting the left S1 nerve at its exit zone and the left L5 nerve in the foramen, the area of protrusion was estimated at 3.5 mm resulting in asymmetric left foraminal narrowing/stenosis.

On May 20, 2011, a neurosurgeon, evaluated the patient for low back pain rated as 7/10 and worsening symptomatology after prolonged sitting and standing. Examination revealed decreased lumbar ROM in forward flexion secondary to pain, antalgic gait, difficulty with toe walking, less difficulty with heel walking and positive SLR on the left at 45 degrees. Sensory examination revealed hypoesthetic region in the L5 and S1 distribution on the left to pinprick and light touch. reviewed MRI of the lumbar spine and diagnosed lumbar radiculopathy, herniated nucleus pulposus (HNP) at L5-S1 and lumbago. He recommended evaluation for epidural steroid injection (ESI).

On June 10, 2011, noted that the patient was doing well. The pain was in the lower back. He noted fair pain control with the current regimen. He recommended a home exercise program (HEP) and ordered EMG.

maintained the patient on naproxen, Norco and Robaxin.

On June 13, 2011, a request was made for transcutaneous electrical nerve stimulation (TENS) unit, brace and analgesic cream.

On July 22, 2011, noted pain in the lower back with numbness and tingling in the left leg. Examination revealed 3/4 lumbar facet L4-S1 paraspinal tenderness with 25% ROM and positive facet rocking. diagnosed lumbosacral facet syndrome. He opined that the patient had failed conservative care and recommended bilateral lumbosacral medial branch nerve blocks at L4-L5.

On October 7, 2011, noted that the ESI was denied. Sensory examination revealed hypesthesia to pinprick and light touch in the L5 and S1 distribution on the left. recommended lumbar laminectomy, discectomy, foraminotomy and partial facetectomy at L5-S1.

On October 14, 2011, refilled medications and recommended bilateral facet medial branch blocks (MBB) at L4-L5.

On October 20, 2011, performed a DDE and opined that the extent of injury was HNP at L5-S1 and recommended an EMG/NCV of the lower extremities and consultation with an orthopedic surgeon.

On October 31, 2011, EMG/NCV of the lower extremities was unremarkable.

On December 9, 2011, the patient underwent a PT evaluation. The evaluator noted that the EMG/NCV was positive for left S1 radiculopathy. He recommended therapy.

2012: From January through May, the patient had regular follow-ups. The reports are unclear.

On January 30, 2012, noted no improvement in previous symptomatology. He ordered CT myelogram of the lumbar spine to better evaluate the L5-S1 disc and for surgical planning.

In February and April, the patient had follow-up who noted worsening condition and recommended bilateral facet MBB L4-L5.

On April 30, 2012, noted no significant improvement in the previous symptomatology. He prescribed OxyContin and opined that the patient was a candidate for surgery at L5-S1.

On May 17, 2012, performed lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L5-S1 on the left.

Postoperatively, examination revealed decreased lumbar ROM in forward flexion secondary to muscle spasm, 5/5 strength throughout, no difficulty with heel or toe walk, negative SLR and no hypoesthetic region to pinprick and light touch. diagnosed status post surgery and recommended walking program.

From May through July, the patient attended some therapy consisting of manual therapy, neuromuscular re-education and therapeutic exercises.

On June 15, 2012, noted pain in the lower back. refilled Naprosyn, Ambien and Ultram and recommended HEP.

On July 2, 2012, noted near complete resolution of the preoperative symptomatology including low back pain. There was peri-incisional muscle spasm and numbness and tingling in the left lower extremity along a nondermatomal distribution. He recommended postop rehab.

From July through October, the patient attended multiple sessions of therapy consisting of neuromuscular re-education and therapeutic exercises.

In August, the patient underwent psychological evaluation and was noted to have significantly high degree of fear avoidance beliefs. The evaluator recommended close supervision and behavioral health intervention during any physical therapy regimen in order to appropriately confront his fears of re-injury.

On August 24, 2012, recommended continuing HEP and follow-up in six weeks.

On August 31, 2012, noted pain rated as 5/10 with worsening symptomatology following prolonged sitting and standing. Examination of the lumbar spine revealed decreased ROM in forward flexion secondary to muscle spasms. He recommended extending postop rehab program.

On September 14, 2012, the patient underwent therapy evaluation and was recommended a trial of work hardening program (WHP).

In October, opined that the patient's progress had plateaued with conservative therapy and without more advanced program he would not be able to return to his original position without increased risk. The employer wanted the patient back to light duty and not full duty. He requested for a multi-disciplinary level of care including a strong behavioral component to facilitate adjustment and timely return to work.

Per utilization review dated October 15, 2012, the request for WHP five per week for two weeks, eight hours per day was denied with the following rationale: *"The patient recently completed lumbar surgery and subsequent physical therapy. The current request is for work hardening to attempt to improve function to the point of full duty work. Documentation indicates that the employer was contacted and light duty was available. No light duty return has been attempted. indicates the opinion that the proposed treatment is the most likely path to successful return to work. The ODG, however, preferentially recommends light duty return to work trial prior to considering work hardening as function in the work environment under protected circumstances is the best form of work simulation. As we know light duty to be available, medical necessity for the proposed treatment cannot be established without a valid return to work trial on light duty."*

From October through November, the patient attended some therapy consisting of therapeutic exercises and neuromuscular re-education.

On October 18, 2012, opined that *"Out of abundance of caution and given the fact that he underwent lumbar surgery five months ago, this program should be approved for this patient. Additionally, his FABQ scores are extremely high indicating the need for close supervision during this program."*

On October 19, 2012, evaluated the patient for pain in the lower back. He recommended PT and work hardening.

On October 22, 2012, the patient underwent psychological evaluation. He scored 9 on the Beck Depression Inventory (BDI) indicating minimal depression, 7 on the Beck Anxiety Inventory (BAI) indicating minimal anxiety, 15/24 on physical activity subscale and 35/42 on work activity subscales of the FABQ. The evaluator recommended WHP.

On November 2, 2012, opined that the patient would benefit from a WHP. He officially discharged the patient from care and recommended follow-up on an as needed basis. He also recommended an FCE for return to work status.

Per reconsideration review dated November 12, 2012, the appeal for WHP five per week for two weeks, eight hours per day was denied with the following rationale: *“Initial level submission reviewed along with basis for that adverse determination. Letter submitted does not provide additional clinical upon which to base overturning the denial. He comments will not give him a letter describing what job the patient could return to. What he fails to mention is that he has the patient’s work status as off work. The employer cannot provide a letter in this context. The August 31, 2012, note documents unremarkable exam except for decreased flexion. Work up for work hardening documents improvement with rehabilitation and average pain level over the past two months of 4/10. BDI and BAI are not elevated. There is isolated elevation of FABQ that may be reinforced by the fact that his treating provider is telling him he cannot work unless he does work hardening. He was supposed to have follow-up with on November 2, 2012, but that note is not provided. Spoke November 7, 2012, at 12:20 p.m. CST. He clarified that in his conversation with Walmart he only wanted clarification as to whether the patient had a job to which to return and was not able to get this information. I reported that I did not have documentation there was no job to which to return. We reviewed the case. I explained that based on the records there is improvement in pain level and function with conservative care. There is not significant psychological overlay except for reported elevated FABQ. Again this is in the context of the patient being told that he cannot go back to work without a WH program. and I interpret the ODG recommendation differently. He does not feel that progressive return to work is appropriate treatment in the postoperative setting. We were not able to agree on the medical necessity of work hardening in lieu of a progressive return to work program.”*

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

Using ODG treatment Guidelines and review of all clinical studies indicate that this 54 years old patient has been under the Doctor’s care for over 30 months. Based on the review of all the records, this patient got injured as a result of lifting box on 6-11-2010. He had a CT scan of lumbar spine which was essentially negative except for some degenerative changes at the facet and intervertebral disc which is pre-existing and could not happened as a result of lifting a box. On 2-21-2011, he had EMG study done by his Doctor at DTI even then his initial neurological examination was negative and ODG treatment guidelines does not recommend this. According to the court record, the EMG center is owned by his doctor, who is not a neurologist. The EMG was read and it was negative. Then ordered an MRI of Lumbar spine even though review of CT study of Lumbar spine was essentially negative and under the ODG treatment guideline was not recommended. The MRI dated 4-22-2011 indicated some Lumbar degenerative changes which was pre-existing and this time some disc bulge of lumbar spine which is very strange since this patient did not have any new injury and the CT of lumbar spine was essentially negative for Disc herniation. Then ironically, order another new and repeat EMG of Lumbar spine to his own center. This time the EMG became suddenly positive for Left S1 radiculopathy? Based on this new positive EMG of

lumbar spine the patient ended up getting the Microdisectomy neurosurgeon. According the patient had stable condition and had some decrease range of motion.

Considering all the mechanism of the injury and diagnosis of Lumbar sprain and strain with some pre-existing degenerative changes of Lumbar spine, under the ODG treatment Guidelines, this case has been managed very poorly. Under the ODG treatment guidelines having the diagnosis of lumbar sprain/strain, 6-8 physical therapy sessions with some home exercise would be indicated beyond that would be medically unreasonable and unnecessary. The question is how could the initial CT scan of Lumbar spine which was initially essentially negative except for some degenerative changes which was pre-existing suddenly when sent to his center, the MRI become positive? How could the Initial EMG study at and owner of DTI be negative and 2 months later when he sent the same patient to DTI ironically the EMG became positive for left S1 radiculopathy without any new injury reported by the patient.as a result, the patient end up getting back surgery.

Based on all the evidence, under the ODG treatment guidelines, no further treatment is indicated and the patient can go back to work on light duty.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES