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Notice of Independent Review Decision
IRO REVIEWER REPORT TEMPLATE –WC

June 24, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 hours of work hardening (10 sessions)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Fellow of the American Academy of Physical Medicine and Rehabilitation

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.

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

office
- Office visits (04/27/12 – 05/22/12)
- FCE (04/30/12)
- Utilization reviews (05/17/12 – 05/30/12)

D.O.
- Diagnostics (04/07/11 – 04/04/12)
- Office visits (04/27/11 – 05/11/12)
- Surgery (08/16/11 – 01/05/12)

Health Direct, Inc.
- Office visits (04/27/12 – 05/22/12)
- FCE (04/30/12)

TDI:

- Utilization reviews (05/17/12 – 05/30/12)

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who injured his lower back on xx/xx/xx. He fell approximately three to four feet and landed on his back and buttocks.

2011: The records start with a magnetic resonance imaging (MRI) of the lumbar spine dated April 7, 2011. The study revealed mild loss of disc space height and signal at L4-L5 and L5-S1, central disc protrusion at L4-L5, a subarticular recess protrusion on the right at L5-S1, midline protrusion at L4-L5 measuring 4 mm in AP extent indenting the ventral thecal sac, protrusion at L5-S1 measuring up to 5-6 mm in AP extent abutting and probably displacing the right S1 nerve root posteriorly, mild central spinal stenosis at L4-L5, facet and ligamentum flavum hypertrophy contributing to the findings, small protrusion in the low thoracic spine at T11-T12 and to a lesser extent at T10-T11.

MRI of the sacrum/coccyx was unremarkable.

D.O., an orthopedic surgeon, evaluated the patient for severe back and leg pain. He noted that the patient had attended one session of physical therapy (PT). Examination revealed slow gait pattern with a cane, inability to heel and toe walk due to pain and weakness in the right lower extremity. Examination of the lumbar spine revealed tenderness in the gluteal and sciatic region on the right, pain with forward flexion at 30 degrees, pain with extension and side bending at 5-10 degrees and pain with rotation. Neurologic examination revealed positive straight leg raising (SLR) and Lasegue's tests on the right. Sensory examination revealed absent light touch in the S1 distribution on the right and decreased sensory to light touch in the lateral skin, lateral thigh and dorsum of the foot on the right. Dr. Benbow diagnosed herniated nucleus pulposus (HNP) at L5-S1 on the right and lumbar radiculopathy; prescribed Norco and Mobic and recommended epidural steroid injection (ESI).

In June, Dr. noted that the patient was status post ESI with 50-60% relief from the injection. The patient reported difficulty ambulating for longer than 10-15 minutes. Examination revealed mild tenderness in the paraspinous region around the L4-L5 and L5-S1 area worse on the left than the right and restricted ROM. Neurological examination revealed a positive SLR on the right and decreased sensation to the light touch along the right lateral thigh, lateral shin and lateral foot on the right compared to the left. The SLR was positive on the right and there was weakness of the gastrosoleus complex at 4/5. Dr. recommended repeat ESI.

In August, Dr. performed an ESI at L5-S1. The patient reported only 30-40% relief for several weeks until he began therapy. The patient complained that the pain was more severe than they were prior to his therapy. Examination revealed a positive SLR, Lasegue's and Cram test on the right and decreased sensory

along the lateral thigh, lateral foot and S1 distribution on the right. Dr. opined that the patient was not responding to medications, PT or rest.

2012: On January 5, 2012, Dr. performed microscopic laminectomy, discectomy, partial facetectomy and neural foraminotomy at L5-S1 on the right and application of dural graft at L5-S1 on the right. Postoperatively, he did extremity well but complained of some back pain, numbness and tingling in the leg. Dr. recommended PT.

On follow-up, Dr. noted ongoing minor buttock pain on the right and some low back pain. Examination revealed some buttock pain with SLR and indirect SLR. There was some slight decreased S1 sensory. The motor strength was improving in the gastrosoleus bilaterally. Dr. recommended total 18 sessions of PT.

In April, Dr. noted that the patient was doing well. He had completed therapy. The patient complained of ongoing pain in the right calf and pain in the heel. Examination of the lumbar spine revealed forward flexion to 40 degrees with some mild pain. Neurologic examination revealed some pain in the back with supine SLR, decreased sensory to light touch in the S1 distribution in the posterior calf area, some swelling of the calf and some pain with compression of the calf. There was some mild weakness of the gastrosoleus with toe raise. Dr. diagnosed three months out from microdiscectomy at L5-S1 on the right, persistent radiculitis, possible deep venous thrombosis (DVT) of the right calf and primary foot pain. He recommended evaluation with a podiatrist, ordered Doppler of the lower extremity to rule out DVT and referred the patient to work hardening program (WHP).

Right leg venous Doppler was unremarkable.

On April 27, 2012, M.D., noted low back pain. Examination revealed flexion to 30 degrees, negative SLR, normal gait and well-healed surgical scar in the lumbar area. Dr. diagnosed lumbar disc disease, status post surgery and recommended WHP. D.O., opined that the patient had exhausted conservative course of treatment and was unable to return to prior levels of functioning and work. He recommended intensive rehabilitation program.

The patient underwent a behavioral medicine consultation. He scored 15 on Beck Depression Inventory (BDI) consistent with mild depression and 20 on Beck Anxiety Inventory (BAI) consistent with moderate anxiety. On Fear Avoidance Beliefs Questionnaire (FABQ) he scored 42 on work as well as 24 on physical activity in general. The evaluator diagnosed chronic pain disorder associated with both psychological factors and a general medical condition and recommended WHP.

In a functional capacity evaluation (FCE) dated April 30, 2012, the patient qualified at a light physical demand level (PDL) versus medium PDL required by his job and was recommended WHP/work conditioning program (WCP).

In May, Dr. recommended continuing Lyrica and Mobic and felt that the patient would need WHP.

Per utilization review dated May 17, 2012, the request for 80 hours of WHP (10 sessions) was denied with the following rationale: *"The mental health evaluation of April 27, 2012, finds impressions of pain disorder, chronic. However, the utilized psychometric instruments are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant clinical/diagnostic information This is especially significant since the patient continues to manifest significant pain behavior, verbally and nonverbally, a significant negative prognostic factor for a work hardening program Relatedly, the FCE of 4/30 reveals all dynamic lifting tests were prematurely terminated secondary to pain behavior, which also casts doubt on the validity of the assessment in relation to PDL job requirements. The provider could not assure that a return to work plan was communicated with the employer; and the submitted job description and notes do not indicate whether or not the patient's job would be available to him. There is no evidence from the patient's treating physician (Dr.) that all other appropriate care has been attempted to restore function. Dr, exam of 4/27 suggests the PMH is "noncontributory." However, the patient is notably obese. Weight is clearly associated with return to work problems, comorbid disability, depression, reduced quality of life, and reduced physical function in this type of chronic pain condition. However, there is no evidence of any responsible or professionally supervised weight loss attempts; and the patient has apparently not been assessed for any specific medical or behavioral intervention in this regard. Weight loss significant enough to materially alter functional, behavioral, and psychological status cannot be achieved during a brief work hardening program. I am not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended."*

On May 22, 2012, PsyD, a psychologist, appealed for WHP and opined that: *"Dr. comments on patient's weight, 265-lbs, height 5 feet 11 inches with his being obese. He was able to have surgery with his weight not being an issue. His blood pressure is normal 118/73. His diabetes is managed with medication (glipizide 10 mg and metformin HCl 1000 mg b.i.d.). Dr. has medically cleared him to do work hardening and so has Dr. on April 4, 2012. Given that he could benefit from weight loss. He will meet with a clinician weekly while in the program to discuss how to implement healthier foods into his diet and exercise with the intention of losing weight. Clinician will also focus on reducing his anxiety about returning to work."*

Per reconsideration review dated May 30, 2012, the appeal for 80 minutes of WHP (10 sessions) was denied with the following rationale: *"Clinical data submitted indicates the worker sustained a low back injury fourteen months ago and underwent L5-S1 microdiscectomy, partial facetectomy and neural*

foraminotomy almost five months ago and has not yet returned to work despite 12 weeks of post-operative physical therapy. The worker has been referred to a work hardening program based on the light physical demand level category performance cited following the functional capacity evaluation of April 30, 2012. The Letter of Appeal highlights the initial reviewer's objections including the breadth and appropriateness of the Mental Health Assessment, the lack of documentation of correspondence with the employer and the lack of assurance the worker's position will be available upon successful completion of the program as well as the worker's body habitus (71 inches and 265 pounds) and lack of confirmation of any form of weight management program having been incorporated to data. The prior reviewer also expressed concern that functional tasks were ceased prematurely on the basis of perceived pain rather than alteration of biomechanical/physiological characteristics; i.e. based on pain perception and pain behaviors. The post-surgical medications are noted to include hydrocodone 10/325 mg t.i.d., meloxicam daily, Lyrica 75 mg b.i.d. and cyclobenzaprine p.r.n. The job requirements are noted to be at the MEDIUM physical demand level while physical performance was at LIGHT physical demand level. The Letter of Appeal notes the worker will have the opportunity to return to work with the employer of record presuming he meets the PDL and is able to work extended hours using heavy equipment. {Preliminary psychological screening inventories have suggested the worker is fearful of re-injury (FABQ, BDI and BAI scores) as is commonly encountered with delayed recovery. Perceived pain levels are in the 2-6/10 range when not physically challenged and the worker perceives his current abilities to be 20 percent of those prior to his injury and surgery.

Peer-to-peer discussion with surgeon revealed the worker has shown improvement in reduction of symptoms and functional activity tolerance since the surgery. The worker did not participate in postoperative physical therapy under his supervision at the facility associated with the surgeon; rather treatment was provided through the Concentra organization. The surgeon does not foresee psychosocial barriers to recovery; rather he believes the worker has the ability to resume his prior employment activities once he meets the physical demand through further strength training and conditioning. The worker is not, however, likely to advance at the necessary pace to complete such training within the limitations set forth in the work conditioning guidelines.

Review of the functional capacity evaluation notes inconsistencies such as minimal heart rate change with exertion, and the commentary that the worker is not safe to sit and walk because of pain levels, the low scores for handgrip strength and the self-limiting performance raise concern raise concern regarding the possibility of exaggeration of limitations. Additionally, there is no evidence of coordination of objective clinical information with the facility that provided the first twelve weeks of minimally invasive post-operative physical therapy. Based on the clinical data submitted, the medical necessity for the worker as opposed to a transitional return to work cannot be established at this time. As noted within the clinical guidelines, the best way to get an injured worker back to work is with a modified duty RTW program, rather than a work hardening or conditioning program. The prior non-certification recommendation is upheld at this time."

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

Discussion is made regarding the past post surgical PT has not resulted in return to unrestricted work. There is discussion of a plateaued state from post surgical PT however, there is no available information supporting exhaustion of a comprehensive post surgical PT program in terms of number of visits, type and extent of PT performed, pre and post PT measured functional analysis, and description on frequency and type of post PT HEP to indicate this baseline level approach to treatment has failed. Concerns exist regarding the high coefficient variables evident in the April 2012 FCE in terms of grip strength analysis and arm lifting of which there is no report regarding injury to the upper extremities to explain this functional deficit.

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

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**