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Notice of Independent Review Decision

December 5, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening five times a week for two weeks

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified Pain Management Physician**

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:

- Utilization reviews (11/11/13, 11/14/13)
- Procedure (11/05/12)
- Diagnostics (02/18/13, 07/24/12)

- Therapy (05/02/13, 10/16/13)
- Reviews (05/14/13)
- Office visits (10/04/13, 10/29/13)
- Utilization reviews (11/11/13, 11/14/13)

Chiropractic Clinic

- Office visits (02/14/12, 10/30/13)
- Procedure (03/09/12)
- Diagnostics (02/18/13, 07/24/12)
- Therapy (05/02/13, 10/16/13)
- Reviews (05/14/13)
- Utilization reviews (10/23/13, 11/14/13)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who felt a pop in his back. This occurred on xx/xx/xx.

On February 14, 2012, M.D., a pain management physician, evaluated the patient for low back pain. The patient described his pain as a constant 5/10 sharp pain in his lower back. There was tingling and numbness down the lateral aspect of his leg to the big toe on the left side. He had some weakness in his leg. Dr. reviewed magnetic resonance imaging (MRI) of the lumbar spine dated October 7, 2011, that showed L3-L4 facet changes. There was a 6-mm disc extrusion at L4-L5 and left foraminal disc herniated nucleus pulposus (HNP) and displacement of the left L4 and L5 nerve roots and facet changes. The patient had undergone physical therapy (PT) which had helped him. He had also utilized medications that had provided him some relief. Examination of the lumbar spine showed limited range of motion (ROM), segmental tenderness around L4-L5 and L5-S1 on the left side, positive seated and supine straight leg raising (SLR) on the left. The neurological examination was intact from L2 to S1 for light touch except lateral calf and top of the foot on the left. Dr. diagnosed discogenic back pain (herniation at L4-L5), lumbar radiculopathy and lumbar sprain. He felt that the patient's back and leg symptoms were most likely related to the L4-L5 disc with compression of the nerve roots. He recommended undergoing left L4 and L5 epidural steroid injections (ESIs). The injection would be both diagnostic and therapeutic. If the pain did not improve then the patient would need surgery.

On March 9, 2012, Dr. performed fluoroscopically guided left L4 and L5 ESI.

On July 11, 2012, M.D., performed a maximum medical improvement/impairment rating (MMI/IR) evaluation. Dr. reviewed a designated doctor report from Dr. dated February 28, 2012, giving MMI on exam date with 5% for a lumbar back strain. Dr. had not given an alternate rating of the lumbar disc. He had noted decreased sensation and significant signs and symptoms. He had given a limited recommendation for ability to return to work. Dr. also reviewed M.D., an orthopedic spine surgeon's consultation note. Dr. had opined that the patient had failed conservative care. He noted that for therapy, the patient had low levels of

care and had had one ESI which showed only a 20% improvement in his pain. The patient had not had any further improvement. Dr. had recommended an L4-L5 anterior posterior fusion with bilateral laminectomy to take pressure off the nerves and relieve his pain. The patient had undergone a presurgical psychological evaluation on May 10, 2012, where he had been cleared as appropriate for surgery. Dr. opined as follows: (1) Contrary to what the designated doctor said, the patient was not at MMI. MMI was premature, as evidenced by the fact that active treatment continued, the carrier authorized ESI after the DDE exam and MMI date. He was still in active treatment attempting to get a recommended L4-L5 anterior/posterior fusion with bilateral laminectomy. He was still having persistent pain in spite of all efforts to relieve the pain. He needed to be considered for surgical intervention by Dr. The patient was being maintained on medications of tramadol and naproxen for pain control.

On July 24, 2012, electromyography/nerve conduction velocity (EMG/NCV) studies showed a left-sided L5 radiculitis. The report is illegible.

On November 5, 2012, Dr. performed L4-L5 anterior spinal fusion, anterior instrumentation, placement of biomechanical interbody device and morselized allograft bone.

2013: On February 18, 2013, computerized tomography (CT) scan of the lumbar spine showed: (1) At L2-L3, there was a 1 to 1.5 mm lateralizing disc bulge extending toward the neural foramina with patency of the neural foramina. (2) At L3-L4, a 1.5 mm broad-based disc bulge mildly effacing the anterior thecal sac without herniation or spinal stenosis. There were mild facet degenerative changes at that level. (3) At L4-L5, bilateral pedicle screws and intervertebral cage appeared well seated. There were anterior screws at the L4 level as well. The hardware appeared well-aligned. (4) At L5-S1, there was a 1.5 mm broad-based disc bulge lying within the anterior epidural space and not impinging upon the exiting neural elements. The neural foramina were widely patent at that level and facet degenerative changes were very mild.

Per an individual psychotherapy note dated May 2, 2013, the patient had attended four (for a total of 14 of 4 authorized sessions of individual psychotherapy) and had reported that it was very helpful to him in various ways. The patient was recommended participating in a functional restoration program.

On May 10, 2013, Dr. evaluated Mr. for low back pain. The patient stated that he was still having some pain at times. Dr. noted that the patient had completed first part of PT. The therapy was helping him. Dr. felt that more therapy could be beneficial. He sent the patient back to the therapy before having him return to work.

On May 14, 2013, M.D., performed a designated doctor evaluation (DDE) and noted the following history: *“Following the injury, the patient reported going to a facility where he underwent x-rays of the lumbar spine that were negative for*

fracture or dislocation. The patient was given pain pills. He returned to work the following day. He was evaluated for complaints of low back pain as well as numbness in the left posterior leg and leg great toe on February 28, 2012. On March 12, 2013, the patient stated he was feeling better but was still having some pain. His pain was radiating down to his left leg. Computerized tomography (CT) scan of the lumbar spine showed healing interbody cage solid interbody fusion at L4-L5. Hardware was in excellent position. There was no evidence of any neural impingement. The patient was recommended PT.” Dr. opined as follows: Based on the medical information obtained in the available medical record, history and physical examination as well as data obtained from ODG, the patient was not at MMI because he had not completed his full course of PT as outlined in the ODG.

On June 20, 2013, a pre-authorization request for 10 visits of active care of work hardening (97545 and 97546) was sent for reconsideration.

On July 12, 2013, Dr. evaluated the patient for low back pain. The quality of pain was described as aching and throbbing. Dr. noted that the patient's fusion had healed. The patient had a good daily home exercise program (HEP) combined with PT regimen. He discussed CT scan findings, which confirmed healed solid fusion and recommended chronic pain management/work hardening and releasing the patient to return to care on a p.r.n. basis.

On October 4, 2013, Dr. evaluated the patient for pelvic pain around the site from the surgery performed in November 2012. The patient stated that his back was doing okay as long as he would not overdo certain movements but at times he would feel a sharp pain around the area of surgery. He had a bulge pop out on his inner left thigh up to his groin area but presently it had gone away. Dr. noted typical groin strain which had completely healed. He noted that the patient's lumbar spine was doing well and recommended a work hardening program (WHP).

In a functional capacity evaluation (FCE) dated October 16, 2013, the patient performed at a light physical demand level (PDL) versus heavy PDL required by his job. He was recommended following to his orthopedic surgeon's recommendation and starting WHP to improve his dexterity, ROM, flexibility, strength, and physical endurance and to also provide the patient with education and pain management skills.

On October 18, 2013, a request for work hardening program (WHP) was submitted.

Per Physician Advisor report dated October 23, 2013, the request for 10 sessions of work hardening was denied with the following rationale: *“The claimant is nearly one year status post surgery and over xx years status post injury. The DD report did not reveal any red-flags that would restrict the claimant from progressing in strength and mobility over the last five months since that examination. Dr. stated the claimant has not returned to work duties. The ODG guidelines #18 state that*

workers that have not returned to work duties within xx years of the accident do not improve with intensive work programs. Additionally, there is no job description from the employer or that the claimant has a job to return to. Given the submitted documentation, recommend non-approval of 10 sessions of work hardening.”

On October 29, 2013, LPC, evaluated the patient and noted that Dr. had recommended and requested that the patient be approved for participation in a WHP. The patient had completed his postsurgical therapy. The patient presented to the clinic for a diagnostic interview in order to determine his candidacy for participation in a WHP. Dr. noted that the patient's mood was slightly dysthymic which his affect was appropriate to content. The Beck Depression Index-II (BDI-II) score was 16 which indicated mild depression and the Beck Anxiety Inventory (BAI) score was 10 which reflected mild anxiety. Diagnosis was pain disorder associated with both psychological factors and medical condition, chronic. It was opined that the patient would benefit from participating in a WHP as he had exhausted conservative treatment yet continued to struggle with pain and functional problems that posted difficulty to his performance of routine demands of living and occupational functioning. Given that the patient was prematurely placed at MMI and that disputes on his case were not resolved for nearly one year, it was neither the patient's choice nor fault that he had not been able to return to work within two years of his injury. It was recommended that the patient be approved for participation in the WHP.

On October 30, 2013, Dr. evaluated the patient for ongoing low back pain. The patient was is showing improvement since starting postsurgical therapy. He continued with less guarding on end ROM testing and appeared with more rotation of the lumbar spine. Rotation of the lumbar spine noted at 15 degrees left, 20 degrees right, extension at 10 degrees, forward flexion at 45 degrees. Although ROM was improving, weakness remained and the patient was easily fatigued. He appeared with a concerned affect, as there had been immediate release of pain but increased bruising at the inner left thigh. There remained very mild swelling at the superior portion of the incision with less fibroid formation. He had guarded movement at all planes but appeared more and more mobile than previous visits. Muscle strength was 4/5 with weakness at left plantar flexion and toe walk. The patient's overall condition was fair. He appeared to be improved significantly with active postsurgical therapy. The patient was to await follow-up report from the specialist. Dr. recommended follow up with Dr. for pain management. The patient had an RME on November 8 and was awaiting approval for program care.

On November 8, 2013, Dr. performed an MMI/IR evaluation and opined that the patient had reached statutory MMI as of September 20, 2013, with 10% whole person impairment (WPI) rating. The patient was still in active treatment at that time and not at clinical MMI.

Per utilization review dated November 8, 2013, the request for ten sessions of WHP was denied by D.C., with the following rationale: *“A peer-to-peer was*

attempted but was not successful on two attempts on separate days. The claimant is currently xx years, xx month post injury. The claimant had a low back surgery in December 2012; the claimant is almost one year post op. The claimant completed 34 visits of postop PT. The recent FCE notes actual lifts performed by the claimant that were from 27 to 38 lbs, these lifts actually fall into the medium PDL. The claimant does not have a job to return back to and the claimant's date of injury is over xx years old. The current request does not meet the ODG criteria. This claimant's date of injury is over xx years old. There is no evidence the claimant has reached a plateau from the PT already provided prior to this request. There is no evidence of attempts to return this claimant to modified work duties or full duty work status prior to the current request. A return to work duties has the best long-term outcome per ODG, even if the claimant requires a gradual transition to full duty work status. There is no written job verification from the employer for this claimant to return to, nor is there a job description/job demand per the employer to support the current request. This claimant should be capable of modified work duties with a gradual transition to full duty work status as advised by ODG. Based on the documentation provided, objective and subjective findings this request is not medically reasonable and necessary. Non-authorization is advised."

In an addendum to the utilization review, on November 11, 2013, Dr. rendered the following opinions: "Addendum-I spoke to the doctor, we discussed the current request on November 8, 2013, at 4:16 PM CST. The doctor thinks the claimant may have a job to return back to, but a job to return back to has not been verified. The notes in the file indicate the claimant does not have a job to return back to currently. Without a verified job to return to following the program, there is no way to maintain an increased functional ability and the claimant will deteriorate back to his prior status. The last FCE noted the claimant was capable of medium PDL lifts up to 38 lbs. these lifts fall into the medium PDL. The claimant should do just as well with a self-directed home exercise program concurrent with returning to work duties in the medium PDL, with a gradual return to full duty work status as recommended by the evidence-based guidelines. The claimant does not meet the ODG criteria for the current request. My prior decision remains the same, unchanged. Non-certification is advised."

Per utilization review dated November 14, 2013, the request for ten sessions of WHP was denied by D.C., with the following rationale: "Employee is over xx years and xx months post low back injury but only one year s/p low back surgery. He has completed postop PT in accordance with ODG and has undergone 14 approved individual psychotherapy sessions. He was given a RTW (return to work) with restrictions but the employer has no light duty. Current PDL is light (values indicate medium) and work required PDL is heavy. Although a RTW program at this time is warranted, Dr. advised me that he was filing for an IRO to appeal the denial for WH; and the request for WC was only submitted because the WH was denied but the employee really requires a multidisciplinary RTW program. In light of this information, it is my opinion that the documentation does not support that the request for WC x 10 sessions is reasonable and/or medically

necessary. Recommend denial of WC x 10 sessions. I spoke with Dr. on November 12, 2013, at 10:31 am CST."

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

Treatment records available report no specific job to return to, no report regarding failure of a daily HEP in conjunction with a modified job duty falling within his FCE results. Due to his response with baseline level PT x 34 visits I would anticipate improved functional abilities during the course of increased activity with modified work and a daily HEP. Psychological assessment reported only mild findings of dysthymic and anxious behavior. Claimant is s/p psychotherapy and should be proficient with behavioral modification skills that should have been taught to him during his psychotherapy. There has been no reported need of psychiatric medications.

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

ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES