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Notice of Independent Review Decision

Date: December 2, 2013

Revised date: December 3, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening program 5 x wk x 2 wks x 80 hours Cervical Thoracic 97545
97546

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

Fellow American Academy of Physical Medicine and Rehabilitation

REVIEW OUTCOME:

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

X Upheld (Agree)

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

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

- Utilization reviews (10/16/13, 11/14/13)
- Office visits (06/15/12 – 11/05/13)
- Therapy (06/15/12 – 06/27/12)
- Utilization reviews (10/16/13, 11/14/13)
- Office visits (09/06/13 - 11/05/13)
- FCE (10/03/13)
- Utilization reviews (10/16/13, 11/14/13)

ODG criteria have been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who was injured on xx/xx/xx. He reported that he felt a sharp pain in his neck and felt his right arm and hand going numb.

On June 15, 2012 evaluated the patient for pain in the neck that had become a little more intense. The patient reported bouts of numbness/tingling down his right arm with associated pain. He had been approved for 12 sessions of active therapy. Examination showed an intense degree of pain from C2 to C8 bilaterally on palpation of the spinal tissues, severe hypertonicity of the suboccipital muscles bilaterally and severe spasticity of the cervical paraspinal muscles bilaterally found on palpation. stated that the patient had shown some progress but was in a subacute phase. Diagnosis was sprain/strain of the cervical region, cervical disc displacement/herniation and cervical radiculitis/root compression.

Through June 27, 2012, the patient was treated with manual therapy, therapeutic exercises, kinetic mobilization therapy and neuromuscular re-education.

No records from July 2012 through December 2012.

On January 2, 2013, the patient underwent a pre-surgical psychological evaluation. He was referred for a behavioral medicine consultation at the directive of surgeon to assess his psychological status and rule out any possible psychological contraindications for the proposed surgery. noted that the patient had injured his neck and back and shoulders on xx/xx/xx, when he felt a sharp pain in his neck and felt his right arm and hand going numb. he was given a shot for pain and was taken off work for a few days. When he returned to work, he lost strength in his right arm. He reported the injury to his supervisor and to the supervisor. The last day he worked was on February 7, 2012. He reported that for his work-related injury, had x-ray series and a neck magnetic resonance imaging (MRI). Passive modalities of treatment had included ultrasound, and heat and ice. He reported participating in 12 physical therapy (PT) sessions. He had one steroidal injection. had asked them evaluate the patient's psychological status for surgical intervention consisting of a cervical fusion from C5-T1. The Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) revealed score of 59 indicating severe depression and 52 reflecting severe anxiety respectively. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W=42) as well as significant fear avoidance of physical activity in general (FABQ-PA=24). Diagnosis was pain disorder, chronic associated with both psychological factors and a general medical condition; major depressive disorder, severe with psychotic features single episode and anxiety disorder NOS. It was felt that the patient was not an appropriate candidate for the proposed cervical surgery. The patient was recommended referral for psychotropic medication consultation and a course of individual psychotherapeutic intervention using cognitive behavioral therapy (CBT). Four weeks of individual psychotherapy was recommended.

On September 6, 2013, the patient reported significant increase in the severity of neck pain. stated that the patient had exhausted conservative care in the form of active therapy and medication management. He continued to exhibit symptoms

such as decreased range of motion (ROM), muscle weakness and radiating pain in the neck. recommended referral to a work hardening program (WHP).

On October 3, 2013, the patient underwent a functional capacity evaluation (FCE). The patient demonstrated a lack of cardiovascular fitness due to deconditioning. It was felt the patient was unable to perform his regular job duties. The evaluator recommended referral to a functional restoration program.

On October 8, 2013, evaluated the patient for work hardening. He reviewed the MRI of the cervical spine. Diagnosis was cervical sprain/strain, cervical disc syndrome and cervical radiculitis. He recommended titration of amitriptyline and WHP.

On October 10, 2013, evaluated the patient for participation in WHP that had been recommended. It was noted that the patient's mood was dysphoric, his affect was constricted and he displayed cognitive distortions including catastrophic thinking. Diagnosis was major depressive disorder, recurrent, severe without psychotic features; anxiety disorder NOS, pain disorder associated with both psychological factors and a medical condition; attention deficit/hyperactivity disorder (ADHD), combined type (by history) and nicotine dependence. It was recommended that the patient be approved for participation in WHP in order to increase his physical and functional tolerance and to facilitate a safe and successful return to work.

On October 11, 2013, a pre-authorization request was submitted for WHP.

Per utilization review dated October 16, 2013, the request for 10 sessions of work hardening program was denied with the following rationale: *"The patient is a male who sustained injuries to his neck, back and shoulders on xx/xx/xx. He is currently diagnosed with neck and back sprain. A request was made for ten sessions of work hardening. The patient has been experiencing pain since sustaining his injury, and has been evaluated to date by various diagnostic studies including x-rays, MRI and electromyography/nerve conduction velocity (EMG/NCV). His cervical MRI on February 27, 2012, was read to have shown a large disc osteophyte complex at C5-C6 with associated moderate-to-severe central canal stenosis, severe right neural foraminal stenosis and severe disc height loss. Disc protrusions and neural foraminal stenoses were also seen at C6-C7 and C7-T1. Treatments rendered to date have included ultrasound, ice, heat, transcutaneous electrical nerve stimulation (TENS), medications, PT (approximately 18 sessions), epidural steroid injection (ESI) (on October 10, 2012), and individual psychotherapy (four sessions from January 2013 to February 2013). It was reported that cervical fusion surgery had also been recommended previously but was denied by the carrier. During his September 6, 2013, follow up the patient complained of a significant increase in the severity of his neck pain. Objective examination demonstrated severe pain upon palpation from C2 to C8 bilaterally, as well as severe hypertonicity of the suboccipital and cervical paraspinal muscles bilaterally. It was reported that the patient also continued to exhibit decreased ROM and muscle weakness. The FCE on October 3, 2013, deemed the patient to be functioning at light physical demand level*

(PDL), while his job reportedly required heavy PDL. Psychological evaluation on October 10, 2013, documented test scores indicative of severe depression (BDI-II score of 37), moderate anxiety (BAI score of 25), and significant Fear Avoidance Beliefs about Work (FABQ-W score of 42) and physical activity (FABQ-PA score of 24). According to the October 11, 2013, pre-authorization request report, the patient showed "moderate improvement" with outpatient PT modalities. The submitted records indicated that the patient needs to re-apply to his former job, and that his employer only allows for full-duty work. Guidelines state that there must be evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment prior to considering work hardening. Although it was documented that the patient had previously attended about 18 sessions of PT with, "moderate improvement," such response was not further elaborated in terms of actual objective measures to demonstrate the functional improvements gained with regular PT and warrant progression to a more intense rehabilitation program such as work hardening. Response to prior individual psychotherapy sessions was also not objectively discussed. Furthermore, clarification is needed as to the target PDL of the patient's previous position as there is a discrepancy between what is indicated in the October 11, 2013, pre authorization request (heavy) and the October 10, 2013, report of work duties (medium). It was also unclear if the patient's previous position is currently still available for him to return to. In consideration of the foregoing issues, the medical necessity of this request is not substantiated at this time. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is noncertified."

On November 5, 2013 reported that an FCE performed on October 3, 2013, indicated the patient to be functioning at a light PDL and the job required a medium PDL. The patient had derived benefit from four sessions of individual psychotherapy. The patient's treating doctor was recommending that the patient be progressed to a WHP due to the patient's persistent functional deficits which were impeding his ability to make a safe return to work on full duty. WHP was recommended.

Per reconsideration review dated November 14, 2013, the request for 10 sessions of WHP was denied with the following rationale: *"As per the submitted medicals and the Utilization Review nurse's clinical summary, the patient in this case is a male who sustained an injury on xx/xx/xx. The patient is currently diagnosed with cervical sprain/strain; cervical disc displacement/herniation; and cervical radiculitis. This is an appeal for the medical necessity of the request for ten sessions of Work Hardening (80 hours) for the cervical and thoracic spine. Updated documentation submitted for this appeal includes the WHP pre-authorization request (reconsideration) dated November 5, 2013. However, this report did not fully address the above-mentioned reasons for the previous non-certification. It states that the patient needs to reapply for his old position. The required PDL is heavy as per the patient, but according to the employer, the required PDL is medium. It was mentioned that in the event that the patient is unable to reach his PDL or no position is available when he applies, the patient*

will receive vocational counseling to help him achieve his employment goals. It is also indicated in the report that after four individual psychotherapy sessions, the following improvements were noted: decreased BAI score (from 52 to 48), decreased depression symptoms and decreased sleep problems. BDI and FABQ scores remained the same. The submitted records for this appeal still did not include documentation of the patient's responses to the previous PT sessions to objectively demonstrate his functional improvements from the rendered treatments. In addition, it is noted that the patient has no clear job to return to at this time. During the peer-to-peer conversation the clinical situation of the patient was discussed. We have discussed the evidence-based practice guidelines as they pertain to this patient and the requested work hardening. has discussed that the treatment goals of the requested program include the progression of the patient to a medium PDL. has discussed that the vocational plans are for the patient to reapply for his former position, which is at a medium PDL, and if unavailable, the patient will look for a similar position to his former occupation. In regards to the previous therapy treatment, we have discussed the ODG provisions for the work hardening treatment, which specify that there should be evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, and with evidence of no likely benefit from continuation of this previous treatment. However, does not have the information regarding the patient's prior physical therapy treatment and his detailed functional response. In consideration of the foregoing issues and the referenced evidence-based practice guidelines, the medical necessity of the requested ten sessions of work hardening (80 hours) has not been established, in agreement with the previous determination. Based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request is not certified."

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

The last pain level reported was 7/10, which is moderate to severe and would prevent full participation in a comprehensive work hardening program, he is only single PDL, light to medium, from achieving the required level, his injury is not to a weight bearing area or lower spine and significant deconditioning should not have occurred and apparently he has to reapply for his position and therefore may not have a position to return to and ODG states "*there should be evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, and with evidence of no likely benefit from continuation of this previous treatment*" which this information was not available in the medical records.

In conclusion, the medical necessity has not been established and does not meet the requirements for the requested work hardening program and the decision is upheld.

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

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES