

CALIGRA MANAGEMENT, LLC
1201 ELKFORD LANE
JUSTIN, TX 76247
817-726-3015 (phone)
888-501-0299 (fax)

Notice of Independent Review Decision

February 11, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening program x10 days (80 hours) for lumbar spine

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

Board Certified Physical Medicine and Rehabilitation Physician

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.

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:

- Physical performance evaluation (11/12/13, 12/18/13)
- Office visits (12/19/13)
- Utilization reviews (01/02/14, 01/10/14)

- Physical performance evaluation (11/12/13, 12/18/13)
- Office visit (12/19/13)
- Utilization reviews (01/02/14, 01/10/14)

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who sustained injury to the lumbar spine on xx/xx/xx, while performing his customary duties. He landed on his right side, back and buttocks. He was unable to get up at first, but his co-worker helped him to his feet. After completing the chore he returned to the job site and reported the incident to his

supervisor, who gave him permission to go home for the day. The next morning he was still in pain when reported to work.

On November 4, 2013, evaluated the patient. recommended functional restoration/return to work program.

On November 12, 2013, the patient underwent physical performance evaluation (PPE). It was noted that the patient had been diagnosed with lumbar disc displacement, muscle/ligament disc not elsewhere classified (NEC) and neuralgia/neuritis, not otherwise specified (NOS). Compensable areas included lumbar spine. The patient had pulling pain in his back. His pain increased on bending forward side to side. At the time of examination, the patient had experienced difficulties with activities of daily living to include lying down, walking, climbing stairs, sleeping and group activities. The patient's current medications included gabapentin, amitriptyline hydrochloride, hydrocodone bitartrate and acetaminophen. The hand written records are illegible.

On December 18, 2013, the patient underwent another PPE. The patient's diagnosis included lumbar disc displacement, muscle/ligament disc disease, nec; neuralgia/neuritis, nos. The patient was recommended participating in work hardening program (WHP). However, the records are illegible.

On December 19, 2013, evaluated the patient for continued participation in WHP recommended by the treating doctor. Results of assessment utilized were follows: (1) Fear avoidance, beliefs questionnaire (FABQ), fear avoidance beliefs about work baseline on November 12, 2013, was 42 whereas currently on December 19, 2013, was 39. There was no change in fear avoidance beliefs. Beck Depression Inventory II (BDI-II) was 42 on November 12, 2013, whereas 36 on December 19, 2013. Beck Anxiety Inventory (BAI) was 3 on November 12, 2013, and 16 on December 19, 2013. Pain was 7 on November 12, 2013, and was the same on December 19, 2013. Irritability was 9 previously and present 6. Frustration was 9 previously and presently 1. Muscle tension was 7 previously and currently 8. Anxiety was 6 previously and presently 1. Depression was 10 previously and currently. Sleep problems were 5 previously and 10 currently. Forgetfulness was 10 previously but 3 currently. Average hours slept was two to three hours previously and presently also two to three hours. Present medications that were used included amitriptyline, Neurontin, Norco and Zantac. The patient was cooperative throughout the interview. He was oriented times five to date, person, place, situation and time. His attention, concentration, psychomotor activity and speech were all deemed to be normal. Intellectual functioning was informally below average. His mood was dysthymic. His affect was constricted. His memory for both recent and remote events was intact. He reported having suicidal thoughts but noted he would not carry them out. His notable behavioral changes included driving more than before, cooking for himself, his invalid mother and occasionally for his brothers. He was washing and ironing his own clothes more than before, was stretching more than before, grocery shopping more than often and socializing more than before. The patient was diagnosed with pain disorder associated with both psychological factors and

a general medical condition, chronic; and major depressive disorder, recurrent, severe without psychotic features. The patient's current assessment of functioning (GAF) was 57, while estimated pre-injury was 80+. Mr. concurred with recommendation that the patient should continue to participate in WHP as he had exhausted conservative treatment and continued to struggle with pain and functional problems that posed difficulty to his performance of routine demands of living and occupational functioning. The patient was recommended participating in WHP in order to further increase his physical and functional tolerances and facilitate a safe and successful return to work.

On December 30, 2013, a preauthorization request was sent for work hardening program. The following additional information was gathered from the preauthorization request: *"As there was no light duty available, the patient had been taken off work. Over the past xx months, he had MRI, EMG/nerve conduction velocity (NCV) studies and he had been recommended for surgery and had completed 20 days of work hardening program. The patient functional capacity evaluation (FCE) dated December 18, 2013, showed following changes: The patient's isometric hip abduction strength on the left was 27.7 on November 12, 2013, whereas it was 31.9 on December 18, 2013. Static push strength was 62.3 previously but 87.7 presently. Pallet to table lift occasionally was 30 on November 12, 2013, whereas it was 40 on December 18, 2013. Table to mid chest lift occasionally was 30 previously and 40 presently. Mid-chest to overhead lift occasionally was 30 previously and 40 presently. Isometric hip flexion strength on the right was 38.7 on November 12, 2013, whereas it was 43.9 on December 18, 2013. The patient had shown moderate improvement with the initial 10 day trial of work hardening program. The patient's was currently performing at a medial physical demand level (PDL) versus very heavy PDL required by his job."*

Per utilization dated January 2, 2014, following additional information regarding medical history was noted: *"Following the injury, the patient was evaluated for complaints of low back pain radiating to the lower extremities. Initial MRI of the lumbar spine identified diffuse disc bulging at L4-L5 with facet degeneration narrowing the thecal sac to 8 mm. The patient underwent physical therapy with no significant improvement. The patient was evaluated on November 30, 2012, with ongoing complaints of low back pain radiating to the lower extremities on the right worse than the left. The patient was a smoker at that visit. Examination revealed mild weakness in the tibialis anterior and extensor halluc longus muscles to the right. There was difficulty with toe and heel walking and the patient reported pain with tandem walking. Straight leg raise (SLR) was positive bilaterally on the right worse than the left. Loss of sensation in L4-L5 nerve root distribution was present. The patient was recommended for additional PT and CT myelogram. The patient had an epidural steroid injection (ESI) on January 4, 2013. Follow-up on January 20, 2013, stated that the patient had no relief from ESIs. Physical examination identified right-sided weakness at the tibialis anterior extensor halluc longus (EHL). There was decreased sensation in a right L4 through S1 dermatome. CT myelogram on March 18, 2013, showed extradural defects at L3-L4 and L4-L5 post CT myelogram identified a 5 mm disc protrusion at L4-L5 effacing the thecal sac with severe narrowing of the lateral*

recesses bilaterally. Follow-up on March 22, 2013, reported no changes on physical examination and the patient was recommended for lumbar decompression followed by posterolateral fusion due to extensive facetectomy planned. The patient underwent a psychological evaluation on March 29, 2013, which identified a dysthymic mood with a constricted affect. BDI score was 27 indicating moderate depression. BAI score was 15 indicating mild anxiety. FABQ scores were 30 for work and 15 for general activities. No psychosocial stressors or uncontrolled depression and anxiety were noted that would prevent the patient from having a reasonable positive post-operative outcome. The patient had an anterior lumbar interbody fusion at L4-L5 with lumbar decompression and posterolateral fusion with pedicle screw instrumentation at L4-L5. The patient completed post operative PT and a course of work hardening x10 visits.”

The request for work hardening program x10 days (80 hours) for lumbar spine was denied based on the following rationale: “A peer to peer was attempted but was not successful on two attempts on separate days. The patient has had a lumbar surgery, since then the patient completed at least 46 visits of post of PT which was followed by 10 visits of a work hardening program of at least 80 hours over the 10 visits. The patient was currently performing at a medium PDL based on the recent FCE exam/evaluation. The current request does not meet the ODG criteria. No significant psychological issues have been identified to support the current request for a multidisciplinary program. There is no evidence the patient has reached a plateau from the PT already provided prior to this request. There is no evidence of attempts to return this patient 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 patient requires a gradual transition to full duty work status. There is no demand per the employer to support the current request. This patient 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 and non-authorization is advised.”

On January 3, 2013, a preauthorization request was sent for reconsideration of the continuation of work hardening program.

Per the reconsideration review dated January 10, 2014, denied the appeal for work hardening program x10 days (80 hours) for lumbar spine. The rationale was as follows: *“I called and spoke at 9:29 AM CT on January 7, 2014. The submitted information and request were thoroughly discussed. No additional information and/or documentation were gathered. The request for 10 additional sessions of work hardening is not medically necessary. First, the submitted information failed to demonstrate significant improvement from 10 prior sessions. Next, the patient placed return to work with requirements of the medium capabilities. The documentation indicated that he is already at this level. As such, there is insufficient information to support additional work hardening.”*

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

Records fail to support medical necessity of additional work hardening in an injury that occurred almost xx years earlier and has not returned to work. There is no documentation demonstrating significant improvement after the first ten WH sessions and does not meet ODG criteria. Therefore, 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