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Notice of Independent Review Decision

June 30, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Work hardening x 10 sessions (80 hours) CPT 97545, 97546

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

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:

ODG criteria has been utilized for the denials.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a female who on xx/xx/xx, felt a pull on her right side of the abdominal areas and her lower back starting hurting a lot.

2012: On xx/xx/xx, evaluated the patient for issues with right thumb, back and stomach. diagnosed abdominal wall pain, lumbar strain and human bite to the right thumb. prescribed Anaprox and Flexeril and scheduled computerized tomography (CT) of the abdomen. placed the patient on restricted work through April 17, 2012.

On xx/xx/xx, x-rays of the lumbar spine and right thumb were unremarkable.

On May 18, 2012, magnetic resonance imaging (MRI) of the lumbar spine showed at L4-L5 there was a 4 mm central bulge of the disc with slight impression on the thecal sac but no impression on the origin of the L5 nerve roots. The disc was borderline hydrated. At L5S1, there was a 4 mm central bulge of the disc and a 4 mm anterior spondylolisthesis of L5 in relationship to S1 secondary to advanced, degenerative facet disease with no impression on thecal sac and no impression on the origin of the L5 nerve roots. There is mild-to moderate but non-constricting neuroforaminal stenosis. The disc was mildly dehydrated and was mildly decreased in height.

On May 18, 2012, CT of the abdomen showed some fatty infiltrations some fat infiltration of the liver. The gallbladder was resected. The left adrenal gland had a 5 mm low attenuated process of the medial limb. The low attenuation of the lesion made the lesion benign at a very high probability. There was a 21 x 21 x 25 mm, mildly lobulated, exophytic lesion of the apex of the left kidney with attenuation measurements too high to diagnosis cyst. A contrast CT scan was strongly recommended versus a renal sonogram, as the lesion might be presumed malignant until proved otherwise. There was very rare left colon diverticulosis. The patient had an appendectomy. The distal most aorta had dense calcification advanced for age. At L5-S1, there was a 4 mm central bulge of the disc and a 4 mm anterior spondylolisthesis of the L5 in relationship to S1 secondary to advanced degenerative facet disease. At L4 and L5, there was a 4 mm central bulge of the disc with slight impression on thecal sac but no impression on the origin of the L5 nerve root. The patient had a umbilical hernia repair history. There was a 6.5 x 3 cm umbilical hernia still present with a 26 mm mouth. The hernia was filled with peritoneal fat but there was a knuckle of small bowel just at the hernia aperture. There was diffuse and severe thinning and atrophy of the right rectus abdominis muscle.

On October 10, 2012, performed a peer review on the patient. He opined that the hernia repair with complete release would be anticipated at a six to eight week. Normally four to six weeks should be sufficient but due to the obesity of the patient and previous surgery, probably it would be a 60 day period. recommended that after the abdominal wall surgery, for the back, the patient needed to be put on aggressive weight reduction program and exercise program. The back did not require any surgical treatment or injection therapy.

On December 6, 2012, performed a robot assisted laproscopic partial nephrotomy with intraoperative ultrasound.

2013: On January 10, 2013, performed a designated doctor evaluation (DDE), on the patient and opined that the alleged lumbar spine and inguinal injuries resulted in work related injury. confirmed the patient's compensable diagnosis to be sprain of lumbar, other specific sites of sprain and strain and inguinal hernia.

On February 1, 2013, evaluated the patient for ongoing issues. The patient reported that the incision was well healed. She had some problems of the left side. She had undergone a partial nephrectomy for treatment of kidney cancer.

She stated that she was not having any pain in a new location. She was utilizing Advair-Diskus, albuterol, Cymbalta, Flexeril, ibuprofen, simvastatin and Xanax. On examination, the patient was noted to have an obese abdomen. The laparoscopic were approximated and dry and well-healed. diagnosed left kidney cancer and recommended to return in three months with urinalysis. The patient was released to full unrestricted duty from Monday.

On March 4, 2013, evaluated the patient for continued back pain that was worse in the morning and somewhat better throughout the day. She also complained of pain located in the right side of the abdomen coming on and off and was worse with lifting. On examination, back extension was found to be 0 degrees, back flexion was 45 degrees, back rotation was 10 degrees, back lateral bending was 10 degrees. diagnosed mechanical low back pain aggravated due to degenerative joint disease (DJD), simple umbilical hernia associated with previous umbilical hernia in 2002, still present on CT. The patient was prescribed Lortab. It was noted that she might need physical therapy (PT) with work conditioning and functional capacity evaluation (FCE). did not feel that her initial abdominal pain was related to her umbilical hernia. Additionally, her original lumbar strain should have been resolved and now her pain was related to her DJD and weight.

On April 5, 2013, the patient complained of pain in the right lower quadrant and aggravated with standing and walking. She also complained of pain in the fifth digit. Ms. diagnosed abdominal pain located in the right lower quadrant, abdominal wall anterior hernia and mechanical low back pain. The patient was prescribed Flexeril and Lortab and instructed to see for evaluation of her abdominal pain/hernia.

From April 27, 2013, through June 19, 2013, the patient was under the care of NP, for complaints of low back pain and abdominal pain. Lortab and Flexeril were refilled. The patient was pending abdominal surgery for hernia repair. placed the patient on no duty due to risk of falling and prevent further complications of abdominal hernia.

On July 3, 2013, evaluated the patient regarding incisional hernia superior to umbilicus per CT. The patient complained of right leg swelling as well as multiple month intermittent mild sharp pain in the right lower quadrant. noted that the patient was initially scheduled for surgery and was found to have leucocytosis and they had to postpone the surgery. She was treated for her leucocytosis. personally interpreted the CT and found the patient to have a small umbilical and incisional hernia superior to the umbilicus. There were no surgical causes of the right lower quadrant pain for a GS standpoint. There was a remote history of L4-L5 disc bulge. The patient was utilizing hydrocodone, acetaminophen, Zyflo, Xanax and Flexeril. diagnosed edema, right lower quadrant abdominal pain and ventral hernia without mention of obstruction or gangrene. Ultrasound Doppler of the bilateral lower extremities was negative. provided the option of surgery versus no surgery and planned to explore to laproscope. did not think that his was due to appendicitis and might be due to adhesions that needed lysis. Regarding the ventral hernia, started the patient on Cefazolin sodium and recommended

laboratory workup. The risks and benefits of open umbilical and incisional hernia repair were discussed.

On July 15, 2013, noted that the patient had surgery scheduled on July 19, 2013, for abdominal hernia. The patient complained of severe low back pain and rated it at 10/10. She also complained of right lower leg pain on walking long distances. Ms. placed the patient off work due to fear of fall, unstable and in severe pain.

On July 19, 2013, performed excision of Meckel's diverticulum and repair of incarcerated incisional hernia repair with mesh, removal of old mesh and development of myofascial flaps x 2 on the left and right respectively.

On July 21, 2013, x-rays of the chest showed stable cardiopulmonary status without convincing pneumonia or other interval cardiopulmonary findings, nasogastric tube courses of the esophagus with its tip doubled back in the GE junction, consider repositioning nasogastric tube and stable generous body habitus.

Per medication reconciliation report dated July 23, 2013, placed the patient on home medications to include Advair, Zocor, Zyflo, Symbicort inhaler, Motrin, Norco and Flexeril.

On September 17, 2013, evaluated the patient for low back pain rated at 10/10. She was requesting medication refills. It was noted that the patient was receiving home health for wound care and methicillin-resistant staphylococcus aureus (MRSA) on incision. On examination, abdomen revealed healing surgical incision with scant yellow drainage. Lortab and Flexeril were refilled and the patient was advised to return to modified work status.

On October 9, 2013, refilled Lortab and Flexeril and recommended continued on modified work status.

On October 18, 2013, performed a DDE and opined that The patient had reached maximum medical improvement (MMI) as of October 9, 2013, with a total impairment at 0 % whole person impairment (WPI) rating.

On November 15, 2013, noted that the patient had a nerve conduction testing that showed nerve damage to both legs. She also had a Doppler studies done which were negative for clots. Examination revealed healing surgical incision on the abdomen. Ms. refilled Lortab and Flexeril and continued the patient on modified duty.

On December 11, 2013, the patient complained of 10/10 low back pain that was increased with movement and she was unable to stand up straight secondary to pain. She also complained of difficulty sleeping due to pain radiating to her legs. There was low back pain. On examination, the patient had muscle tenderness and joint tenderness. The lumbar spine showed abnormal range of motion (ROM). There was spinal tenderness located in the L4-S1 area. Lumbar forward

flexion was 60 degrees; extension was 0 degrees, right/left lateral bending 10 degrees. The patient was prescribed Norco and Flexeril and recommended PT three times a week for three weeks.

2014: On January 10, 2014, performed a medical evaluation on The patient and opined that based on the mechanism of injury reported. The patient was significantly obese and this condition was a single most influential factor in her continued complaints. It was felt that she might have had a slight aggravation at the time of her accident, but felt that the mechanism of injury did not support the degenerative findings on the MRI. It was felt that the diagnosis as it related to the date of the injury on xx/xx/xx, was lumbar sprain and recurrent inguinal hernia which required repair. No other conditions were related to her accident.

In an FCE, The patient performed at a sedentary physical demand level (PDL).

On January 16, 2014, evaluated the patient for lower back pain radiating down to both legs. The patient rated her pain at 10/10. She noted that she had bilateral leg pain from her knees down. She had an MMI in October 2013, and was assigned 0% disability. She continued to argue that everything that goes wrong was related to her lower back. On examination, the patient was found to be obese. Musculoskeletal examination showed joint tenderness and over central L4-S1. Lumbar spine ROM was forward flexion 60 degrees, extension 0 degrees and right/left lateral bending 10 degrees. The patient pointed at the L4-S1 area as her point of origin of pain stated that it did not radiated anywhere. She stated that the pain was constant and always present. diagnosed lumbar sprain and mechanical low back pain. The patient was recommended to return to modified work status.

On February 26, 2014, performed an initial evaluation on the patient for ongoing persistent issues. The patient had low back pain and ventral hernia as an injury to her lumbar spine. On examination, palpation revealed muscle spasm bilaterally in the lumbar spine region. The pain was stabbing and burning quality extending from low back to both lower extremities into feet. Lumbar ROM was flexion 40/80 degrees, extension 10/30 degrees and bilateral lateral flexion 10/30 degrees. The patient was positive for Kemp's test, SLR bilaterally and Linder's sign. recommended therapy to improve strength, function and conditioning. The short-term goals were to reduce symptoms and pain level and increased ROM. The long-term goals were to reach MMI as soon as possible.

From April 2, 2014, through May 19, 2014, the patient underwent a total of 10 physical therapy (PT) sessions.

On April 30, 2014, noted that the patient had completed six PT sessions and the lumbar spine ROM had improved with flexion from 40 to 60 degrees, extension from 10 to 20 degrees and bilateral lateral flexion from 10 to 20 degrees. In addition to the improved ROM, there was also lowered pain levels and decrease in the usage of Flexeril and hydrocodone as pain medications. The patient

continued with pain with ROM and muscle guarding. recommended additional four PT treatment sessions over the next four weeks.

On May 20, 2014, noted that the patient had completed the additional four PT treatment sessions for the lumbar spine. There was additional improvement seen in the lumbar ROM as well as pain levels. Overall, the pain levels had continued to improve through the course of exercise. The lumbar ROM was measured flexion 65 degrees, extension 25 degrees and bilateral lateral flexion 25 degrees. The patient continued to take medications hydrocodone and Flexeril for the lumbar spine pain, however, she was unable to decrease the amount. Overall, the patient had made very good progress. The patient also lost 7 lbs after initiating PT. She went down from 235 lbs to 228 lbs. recommended continuing therapy and getting a mental health evaluation to determine if she was better suited for work conditioning program or an interdisciplinary work hardening program.

On May 20, 2014, evaluated the patient at the request. The patient complained of back pain and intermittent sleep disturbances due to pain and racing of thoughts and having difficulty adjusting towards her injury. The patient was having difficulty managing her pain and experiencing a great deal of interference with activities of daily living due to her pain. She also experienced stress. She felt more sensitive and became more emotional since her injury. On the Beck Depression Inventory II (BDI II), the patient scored 28 placing her in the moderate range and on the Beck Anxiety Inventory (BAI) she scored 25 placing her in the moderate range of assessment. diagnosed Axis I: Sprain of the lumbar spine and opined that the behavioral issues would be appropriately addressed by a multidisciplinary program with both behavioral and physical modalities.

Per a preauthorization request dated May 22, 2014, a request for 10 work hardening treatment sessions was made.

On May 22, 2014, performed a functional capacity evaluation (FCE) on the patient and assessed her current PDL to be sedentary versus her job requiring medium PDL.

Per utilization review dated May 28, 2014, the request for work hardening x10 sessions (80 hours) was denied with the following rationale: *"A work hardening program is being requested for a diagnosis of lumbar strain. This patient sustained a lumbar strain on xx/xx/xx. There is no objectively identifiable and currently ongoing occupational pathology that explains and accounts for the patient's alleged lack of physical ability. In addition, the patient has no job to RTW to Guidelines stated "RTW plan; A specific defined return to work goal or job plan has been established, communicated and documented." The patient was previously employed and there is no indication that the PDL of the job was greater then light which is not a PDL level that even requires a work hardening program per ODG. The patient completed 10 supervised rehab sessions earlier in 2014 with no lasting subjective, objective or functional improvement. There is extensive documentation of abnormal illness behavior per the designated doctor an impartial*

party. Guidelines state contraindications to this program: There is no evidence of other medical, behavioral, or other co-morbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return to work upon program completion."

Per a reconsideration request letter dated May 29, 2014, requested reconsideration for initial 10 visits for work hardening.

Per reconsideration review dated June 4, 2014, the request for work hardening x10 sessions (80 hours) with the following rationale: *"According to the 47 pages submitted documentation, the patient, a female reported low back pain on xx/xx/xx. The request is for 10 sessions of work hardening. The designated doctor examination dated October 18, 2013, noted exaggerated limitations of ROM and opined the patient was at MMI at 0% impairment. The DDE dated January 10, 2014, noted mild decrease in ROM. The SLR was not consistent and no sensory motor deficits. The designated doctor opined the patient was at MMI with 0% impairment. FCE rated the patient at sedentary PDL. The initial examination report dated February 26, 2014, noted decreased lumbar ROM and positive orthopedic test and hypoesthesia bilaterally, right and left lower extremity along the L5-S1 dermatomes. The FCE dated May 22, 2014, rated the patient the sedentary level demonstrating the ability to only lift 5 lbs. As a designated doctor whose opinions carries presumptive weight noted positive Waddell's sign and exaggerated limitations of ROM. The FCE dated May 22, 2011, suggested that the heaviest weight the claimant to lift was 5 pounds. The ODG treatment guidelines do not recommend work hardening program or workers with PDL below medium level injury with the worker has been off work. There is no job description from the employer outlining the specific job duties of the patient given the submitted documentation, the appeal correspondence and the peer-to-peer the request does not appear to be medically necessary or in keeping with the ODG treatment guidelines. Recommended non-approval of 10 sessions of work hardening."*

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

GOE: 11.02.01 STRENGTH: L GED: R5 M4 L5 SVP: 7 DLU: 81

Source: Description of Job and physical demand levels, from the DOT's Dictionary of Occupational Titles. (http://www.occupationalinfo.org/) 6-29-2014

Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a

valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).

Source: ODG (http://www.odg-twc.com/) 6/29/2014

Answer: Based on ODG the effectiveness of a work hardening program must be generally in the medium or higher demand level. Per DOT the demand level is light. In addition there is no documentation of evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks.

Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

Source: ODG (http://www.odg-twc.com/) 6/29/2014

Answer: There is evidence of other medical comorbidities; Obesity, advanced degenerative disc disease of the lumbar spine. The patient had a umbilical hernia repair history. There was diffuse and severe thinning and atrophy of the right rectus abdominis muscle.

RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.

Source: ODG (http://www.odg-twc.com/) 6/29/2014

Answer: There is no evidence of a specific defined return to work goal or job plan that has been established, communicated or documented.

Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs.

Source: ODG (http://www.odg-twc.com/) 6/29/2014

Answer: The injured worker is past the date of injury. After this time frame workers generally do not improve from intensive work hardening programs.

Because of these factors a work hardening program is not reasonable or medically necessary.

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

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