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

Notice of Independent Review Decision

September 17, 2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Ten sessions of work conditioning

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Physical Medicine and Rehabilitation Physician

REVIEW OUTCOME:

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

X Overturned (Disagree)

Medical documentation **supports** 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.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male, who sustained a work-related injury to his lumbar area on xx/xx/xx. The patient felt pain in the lumbar area radiating down the bilateral lower extremities.

On March 27, 2014, APRN, evaluated the patient for bilateral low back pain. The patient rated the pain at 6/10 with soreness. noted that the patient had not sought any medical attention elsewhere. Examination of the lumbar spine revealed tenderness to palpation. Otherwise, the lumbar spine was within normal limits. Ms. diagnosed sprain and strain of other and unspecified parts of the back/lumbar spine and recommended x-ray of the lumbar spine. The patient was instructed to return if symptoms worsen or persist.

On March 27, 2014, x-ray of the lumbar spine was unremarkable for acute abnormalities.

On April 3, 2014, noted the patient had increase in the pain due to activity at work and rated the pain at 7/10. He demonstrated poor body mechanics when asked to pick up a paper from the floor. Examination of lumbar spine revealed mild right lumbar spine tenderness and normal lumbar range of motion (ROM) but with pain. Ms. prescribed Medrol Dosepak and ibuprofen and recommended a physical rehabilitation. The patient was instructed on proper body mechanics and recommended to return to full duty with intent not to aggravate.

From April 8, 2014, through April 11, 2014, the patient was under the care of PT. for physical therapy (PT) treatments. The patient continued with back pain at 7/10. Lumbar examination revealed tenderness to palpation over the lower spine and lumbar flexion at 100 percent, extension at 75 percent, right side bend at 100 percent and left side bend at 75 percent. The treatment modalities included therapeutic exercises, therapeutic acts, manual therapy, electrical stimulation, traction and hot/cold packs. The patient had no significant change in symptoms.

On April 15, 2014, the patient underwent a PT evaluation for back issues. The patient was utilizing ibuprofen and methyl prednisolone. He reported difficulty sleeping due to pain. He had difficulty standing, reaching and prolonged sitting. The back examination noted bilateral tenderness, spasm and guarding to the L2-L5 spinous process in the right sacroiliac joint. Bilateral L5-S1 radiating pain was noted. Motor strength was noted to be rated at 5/5. The ROM for the lumbar spine was noted to be at 55 degrees flexion, 10 degrees extension, 20 degrees left lateral flexion, 15 degrees right lateral flexion, 20 degrees left rotation and 15 degrees right rotation. There was positive Kemp's testing in lumbar spine and bilateral hamstring tightness. The patient was diagnosed lumbar sprain/strain, recommended PT and referral for evaluation/treatment.

From April 16, 2014, through May 14, 2014, the patient underwent PT with modalities to include therapeutic exercises, massage therapy and neuromuscular reeducation.

On May 9, 2014, evaluated the patient for complaints of low back pain. A magnetic resonance imaging (MRI) of lumbar spine showed L5-S1 disc herniation and ligament tear. referred the patient to a pain specialist for epidural steroid injection (ESI) and recommended continuing medications and PT three times a week for three weeks. A Back brace was ordered and the patient was continued on light duty status.

On May 14, 2014, noted improving flexibility/ROM with therapy but persistent end ROM pain and radiating pain/paresthesia in the bilateral lower extremities. The patient was referred to a pain specialist.

On May 21, 2014, evaluated the patient for 6-7/10 low back pain radiating to the lower extremities. The patient described the pain as burning, sharp, shooting and aching with associated numbness and tingling. The pain was aggravated with bending, sitting and lying down. He was currently off work. The patient was

utilizing ibuprofen, cyclobenzaprine and hydrocodone. MRI of the lumbar spine dated May 7, 2014, showed early disc desiccation at L4-L5 level with shallow central disc bulge, which effaced the thecal sac, did not compromise the neural foramina. At L5-S1 level, there was early disc desiccation with shallow central disc herniation that slightly effaced the thecal and did not affect the neural foramina. Examination of the lumbosacral spine revealed tenderness in lumbar spinous process at L4-L5 and L5-S1 levels. Lumbar paraspinal muscles were tender to palpation bilaterally, diffusely localized throughout. The lumbar ROM was flexion 50 degrees and extension 10-15 degrees. Reflexes of the lower extremities were 2+/4 bilaterally. diagnosed lumbago and multilevel lumbar disc herniation without central canal stenosis/nerve root compression and/or foraminal stenosis. noted that the patient was not a candidate for interventional pain management injection in accordance with ODG guidelines. He recommended continuing PT and return in one month for follow up.

On May 30, 2014, noted the patient had constant low back pain with bilateral leg pain and pins/needles sensations. The patient had difficulty sleeping/disturbed sleep due to pain. A functional capacity evaluation (FCE) was recommended.

On June 12, 2014, the patient underwent an FCE and demonstrated the ability to safely and dependably perform at a sedentary-light physical demand level (PDL) versus a heavy PDL per his current job requirement.

On June 17, 2014, the patient continued with 7/10 back pain with episodic radiation into the lower extremities. He indicated that the therapy was helping with improvement in function. noted the patient was utilizing hydrocodone/Flexeril/Motrin prescribed. discontinued hydrocodone and prescribed Ultram, Flexeril and Motrin. The patient was recommended weaning off pain medications from the next office visit with anticipation in returning back to workforce. He was to return in one month.

On June 20, 2014, referred the patient for a work conditioning program (WCP) to address current functional deficits.

On July 11, 2014, noted the patient was pending authorization for WCP. The patient had constant low back and left leg radiating pain with intermittent right leg radiating pain. He had a positive Kemp's test with bilateral lumbar paraspinal tenderness. The patient was to follow-up.

On July 15, 2014, the patient complained of generalized back pain at 2/10 with medications. He reported that he was using Ultram mainly and Flexeril and Motrin on occasions. He still had not returned to workforce. Lumbar examination revealed ROM flexion 45-50 degrees and extension 10-15 degrees. There was tenderness to lumbar spinous process at L4-L5 and L5-S1 levels. The lumbar paraspinal muscles were tender to palpation bilaterally. discontinued Flexeril and Motrin and recommended continuing Ultram for pain. The patient was also recommended FCE to determine PDL to return back to workforce. He was to return on an as-needed basis.

Per a utilization review dated July 16, 2014, the request for work conditioning program five times a week for two weeks, total of 30 hours, to the lumbar spine was denied with the following rationale: *"The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. The patient is a male who reported an injury on xx/xx/xx. His diagnoses included lumbar sprain/strain. His current medications were noted to include Ultram 50 mg twice a day as needed, Flexeril 10 mg one at night as needed and Motrin 800 mg one a day as needed. His surgical history was not noted in the documentation provided. The diagnostic studies were not noted in the documentation provided. Other therapies were noted to include physical therapy. The patient was evaluated on April 8, 2014, for reports of low back pain rated at 7/10. The examination noted tenderness to palpation over the lower spine and lumbar flexion at 100 percent, extension at 75 percent, right side bend at 100 percent and left side bend at 75 percent. The treatment plan included physical therapy. The patient was evaluated on April 10, 2014, and April 11, 2014, with no significant changes noted. The patient was evaluated on April 15, 2014, for a physical therapy evaluation. The examination noted bilateral tenderness, spasm and guarding to the L2-L5 spinous process in the right sacroiliac joint. Bilateral L5-S1 radiating pain was noted. Motor strength was noted to be rated at 5/5. The range of motion for the lumbar spine was noted to be at 55 degrees flexion, 10 degrees extension, 20 degrees left lateral flexion, 15 degrees right lateral flexion, 20 degrees left rotation and 15 degrees right rotation. The patient was seen by physical therapy on April, 16, 2014, April 17, 2014, April 23, 2014, April 25, 2014, May 6, 2014, May 7, 2014, May 9, 2014 and May 14, 2014, for physical rehabilitation. The patient was evaluated on April 22, 2014. The examination noted lumbar spine tenderness at L4-S1 at the L4-S1 paravertebral area radiating to the bilateral lower extremities. A positive straight leg raise was noted. The treatment plan included an MRI of the lumbar spine, an EMG of the bilateral lower extremities, continued physical therapy, medications and a back brace. The patient was evaluated on April 29, 2014, and May 14, 2014, with no significant changes noted. The patient was evaluated on May 21, 2014, for a pain management evaluation. The examination noted the range of motion to be at 50 degrees for flexion and 10 to 15 degrees for extension. The patient was evaluated on May 30, 2014, with no significant changes noted. The patient was evaluated on June 12, 2014, for a functional capacity evaluation which noted to reveal the patient was at a sedentary light physical, demand level, which failed to meet the minimum job requirements for his job. The patient was evaluated on June 17, 2014, for a pain management follow up. The treatment plan included discontinuing the patient's hydrocodone and continued weaning off pain medication. The patient was evaluated on June 20, 2014, and the treatment plan included a referral for a work conditioning program to address current functional deficits. The patient was evaluated on July 11, 2014, for reports of continued low back pain radiating to the left leg with intermittent right leg radiating pain. A positive Kemp's test, bilateral lumbar paraspinal tenderness, and lumbar flexion and extension and range of motion pain were noted. The treatment plan included work conditioning program. The Official Disability Guidelines may recommend a work conditioning program when an additional series of intensive physical therapy*

visits are required beyond the normal course of physical therapy for exercise training and supervision. The guidelines further state that a work conditioning program would be contraindicated if there is already significant psychosocial, drug, or attitudinal barriers to recovery not addressed by the program. Although the patient does continue to have functional deficits as indicated in the documentation provided, there is a significant lack of clinical evidence of progression with the prior physical therapy treatments as indicated by documentation of increased range of motion and strength. There is a lack of comparative documentation upon completion of the physical therapy series to show the efficacy of the therapy and continued functional deficits in the documentation provided. Furthermore, there is a significant lack of evaluation of the patient's psychosocial and attitudinal barriers. Therefore, due to the significant lack of clinical evidence of evaluation of the efficacy of the prior physical therapy treatments and evaluation of the patient's psychosocial and attitudinal barriers, the request for a work conditioning program five times a week times two weeks for a total of 30 hours to the lumbar is non-certified."

Per a reconsideration review dated August 5, 2014, the appeal for work conditioning program five times a week for two weeks, total of 30 hours, to the lumbar spine was denied with the following rationale: *"This patient was injured on xx/xx/xx. reports that he was injured while lifting. He has received conservative care and physical therapy. He has been denied for additional diagnostic testing. Reportedly, he has no job to return to. states that the employer will not offer him modified duty. He is designated as an iron worker by the treating doctor, a heavy demand category. Currently, FCE testing performed on June 12, 2014, demonstrated that he can perform in the light demand category. states that this patient has no other options for treatment left. feels that this patient does have more than a soft tissue injury. He displays radiating leg pain, right greater than left. Reportedly, nerve tensions signs are positive. He is taking hydrocodone but the record shows that the plan was to wean him off. states that this patient has not had an MRI, which would be optimal, so they will proceed to a RTW program. This request was previously denied based upon the patients' lack of demonstrated improvement with the previous course of care. He is not likely to achieve a return to work status as ODG criteria mandate."*

On August 8, 2014, noted the patient had constant low back and left leg radiating pain. The patient reported increase in pain intensity with increased daily activities. Examination showed positive Kemp's, positive left seated SLR at 90 degrees, bilateral lower lumbar paraspinal spasms, tenderness and left sided lumbar end ROM pain. noted that WCP was denied by the carrier. The impairment rating was kept on hold pending designated doctor evaluation (DDE) for maximum medical improvement (MMI). The patient was to follow-up in three weeks.

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

Based on the medical records and ODG does indeed meet the criteria for work conditioning as noted below:

“Work conditioning is “recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty RTW program (see ODG Capabilities & Activity Modifications for Restricted Work), rather than a work conditioning program, **but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful**. The ODG Work Conditioning (WC) Physical Therapy Guidelines state: WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work”. Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

The employer states clearly they do not have modified duty and therefore the WC is a reasonable option. Although he may or may not have a specific employer to return to this occupation, but the requirements are known and he should be able to find immediate employment in the same field.

Therefore, it is my opinion the decision should not be 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