

# P&S Network, Inc.

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**DATE OF REVIEW:** October 9, 2007

**IRO CASE #:**

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

This case was reviewed by a Pain Management, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work conditioning x 20 sessions

**REVIEW OUTCOME:**

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

Upheld (Agree/Noncertify)

**REVIEW OF RECORDS:**

- o Submitted medical records were reviewed in their entirety.
- o September 5, 2007, Peer Review, Dr.
- o September 14, 2007, Peer Review, Dr.
- o August 21, 2007, Progress Report, Dr. DC
- o September 10, 2007, Request for Reconsideration, Dr., DC
- o December 26, 2007, Supplemental Report, Dr.
- o September 25, 2007, Treatment/Billing History, Mr.
- o June 8, 2007, Impairment Rating, Dr.

**CLINICAL HISTORY SUMMARY:**

According to the medical records, the patient sustained an industrial injury on xx/xx/xx when a tire exploded and struck him on the hip and knocked him to the ground. The claimant was given diagnoses inclusive of: lower back pain, right hip pain, probable greater trochanteric bursitis, impingement syndrome of the left shoulder, and left heel pain. The patient was treated conservatively. X-rays were obtained which demonstrated hypertrophic changes at L2-L3. An MRI of the lumbar spine was performed on August 23, 2007, which demonstrated disc dehydration at L2-L3. Additionally, the patient underwent electrodiagnostic testing which demonstrated findings consistent with bilateral L5 radiculopathy without chronic changes and early irritation of the left S1 nerve root. This is inconsistent with the imaging study. The patient underwent an MRI of the right hip on July 20, 2007, which demonstrated a small right hip joint effusion and mild distention of the ileopsoas bursa. The injured worker has completed 29 hours of one-on-one physical therapy (not including passive modalities), 10 sessions of work hardening, and 25 sessions of pain management.

The patient underwent an Impairment Rating Examination on June 8, 2007, at which time the patient was given an impairment rating of 2% Whole Person Impairment based upon American Medical Association Guidelines.

The patient underwent a Functional Capacity Evaluation prior to initiating his work conditioning program. Additionally, he underwent a Functional Capacity Evaluation after the completion of 10 sessions of work conditioning. The patient made only mild improvements. Initially, he was rated at a light-medium functional performance. After the completion of 10 sessions, he was rated at occasional medium level and frequent light-medium level. This would not indicate substantial improvement. The

medical records indicate that the patient has a job to return to and needs to transition back to work as a laborer at the Heavy PDL.

**ANALYSIS AND EXPLANATION OF DECISION:**

Based on the medical literature and the medical records provided for my review, I recommend to noncertify the request for 20 sessions of work conditioning.

As noted above, the patient has already completed 10 sessions of work conditioning. He underwent a Functional Capacity Evaluation after the completion of 10 sessions of work conditioning. The patient made only mild improvements. Initially, he was rated at a light-medium functional performance. After the completion of 10 sessions, he was rated at occasional medium level and frequent light-medium level. This would not indicate substantial improvement to warrant an extended program. Additionally, as noted in the references, utilization of Functional Capacity Evaluations to evaluate return-to-work show mixed results.

As noted by the Official Disability Guidelines, specific parameters for the total number of work conditioning sessions are consistent with recommendations for the number of physical therapy sessions that may be recommended (please see below). For low back pain, nine sessions may be recommended. The patient has already completed 10 sessions of work conditioning would only minimal improvement.

Therefore, recommendation is to noncertify the request for 20 sessions of work conditioning.

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

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines 2007, work conditioning and work hardening may be recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapist or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with

chronic back pain, when compared to usual care. However, there is no evidence of their efficacy for acute back pain. (Schonstein-Cochrane, 2003) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. (CARF, 2006) (Washington, 2006) Use of Functional Capacity Evaluations (FCE's) to evaluate return-to-work show mixed results. See the Fitness For Duty Chapter. See Physical therapy for the recommended number of visits for Work Conditioning. For Work Hardening see below.

Criteria for admission to a Work Hardening Program:

1. Physical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
2. A defined return to work goal agreed to by the employer & employee:
  - a. A documented specific job to return to, OR
  - b. Documented on-the-job training
3. The worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program.
4. 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 may not benefit.
5. Program timelines: Work Hardening Programs should be completed in 4 weeks or less.

Official Disability Guidelines - Treatment in Workers' Compensation. ODG, Physical therapy. Recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. See also Exercise. Direction from physical and occupational therapists can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. (Hayden, 2005) Studies also suggest benefit from early use of aggressive physical therapy ("sports medicine model"), training in exercises for home use, and a functional restoration program, including intensive physical training, occupational therapy, and psychological support. (Zigenfus, 2000) (Linz, 2002) (Cherkin-NEJM, 1998) (Rainville, 2002) Successful outcomes depend on a functional restoration program, including intensive physical training, versus extensive use of passive modalities. (Mannion, 2001) (Jousset, 2004) (Rainville, 2004) (Airaksinen, 2006) One clinical trial found both effective, but chiropractic was slightly more favorable for acute back pain and physical therapy for chronic cases. (Skargren, 1998) A spinal stabilization program is more effective than standard physical therapy sessions, in which no exercises are prescribed. With regard to manual therapy, this approach may be the most common physical therapy modality for chronic low back disorder, and it may be appropriate as a pain reducing modality, but it should not be used as an isolated modality because it does not concomitantly reduce disability, handicap, or improve quality of life. (Goldby-Spine, 2006) Better symptom relief is achieved with directional preference exercise. (Long, 2004) See also specific physical therapy modalities, as well as Exercise; Work conditioning; Lumbar extension exercise equipment; McKenzie method; & Stretching. [Physical therapy is the treatment of a disease or injury by the use of therapeutic exercise and other interventions that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, activities of daily living and alleviating pain. (BlueCross BlueShield, 2005)]

Patient Selection Criteria: Multiple studies have shown that patients with a high level of fear-avoidance do much better in a supervised physical therapy exercise program, and patients with low fear-avoidance do better following a self-directed exercise program. When using the Fear-Avoidance Beliefs Questionnaire (FABQ), scores greater than 34 predicted success with PT supervised care. (Fritz, 2001) (Fritz, 2002) (George, 2003) (Klaber, 2004) (Riipinen, 2005) (Hicks, 2005) Without proper patient selection, routine physical therapy may be no more effective than one session of assessment and advice from a physical therapist. (Frost, 2004) Patients exhibiting the centralization phenomenon during lumbar range of motion testing should be treated with the specific exercises (flexion or extension) that promote centralization of symptoms. When findings from the patient's history or physical examination are associated with clinical instability, they should be treated with a trunk strengthening and stabilization exercise program. (Fritz-Spine, 2003)

Post Epidural Steroid Injections: ESIs are currently recommended as a possible option for short-term treatment of radicular pain (sciatica), defined as pain in dermatomal distribution with corroborative findings of radiculopathy. The general goal of physical therapy during the acute/subacute phase of injury is to decrease guarding, maintain motion, and decrease pain and inflammation.

Progression of rehabilitation to a more advanced program of stabilization occurs in the maintenance phase once pain is controlled. There is little evidence-based research that addresses the use of physical therapy post ESIs, but it appears that most randomized controlled trials have utilized an ongoing, home directed program post injection. Based on current literature, the only need for further physical therapy treatment post ESI would be to emphasize the home exercise program, and this requirement would generally be included in the currently suggested maximum visits for the underlying condition, or at least not require more than 2 additional visits to reinforce the home exercise program. ESIs have been found to have limited effectiveness for treatment

of chronic pain. The claimant should continue to follow a home exercise program post injection. (Luijsterburg, 2007)  
(Luijsterburg2, 2007) (Price, 2005) (Vad, 2002) (Smeal, 2004)

ODG Physical Therapy Guidelines -

Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT.  
Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface.

Sprains and strains of back:

10 visits over 5 weeks

Lumbago:

9 visits over 8 weeks

Intervertebral disc disorders:

Medical treatment: 10 visits over 8 weeks

Post-injection treatment: 1-2 visits over 1 week

Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks

Post-surgical treatment (fusion): 34 visits over 16 weeks

Spinal stenosis:

10 visits over 8 weeks

Sciatica:

10-12 visits over 8 weeks

Fracture of vertebral column without mention of spinal cord injury

Medical treatment: 8 visits over 10 weeks

Post-surgical treatment: 34 visits over 16 weeks