I-Decisions Inc.

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Notice of Independent Review Decision

DATE OF REVIEW: MAY 15, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

24 units of 97545 and 142 units of 97546

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

AADEP Certified
Whole Person Certified
TWCC ADL Doctor
Certified Electrodiagnostic Practitioner
Member of the American Board of Clinical Neurophysiology
Clinical practice 10+ years in Chiropractic WC WH Therapy

REVIEW OUTCOME

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

☐ Upheld (Agree)

☐ Overturned (Disagree)

☒ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Injury Date	Claim Number	Review Type	Begin Date	End Date	ICD-9/DSMV	HCPCS/ NDC	Billing modifiers	Service Amounts	Upheld/Overturned
Xx/xx/xx	*xxxxx*	*RETRO*	*2/19/07*	*2/23/07*	*71957*	*97545*	*WH-CA*	*5*	*Overturned*
Xx/xx/xx	*xxxxx*	*RETRO*	*2/19/07*	*2/23/07*	*71957*	*97546*	*WH-CA*	*30*	*Overturned*
Xx/xx/xx	*xxxxx*	*RETRO*	*2/26/07*	*3/30/07*	*71957*	*97545*	*WH-CA*	*19*	*Upheld*
Xx/xx/xx	*xxxxx*	*RETRO*	*2/26/07*	*3/30/07*	*71957*	*97546*	*WH-CA*	*112*	*Upheld*

The reviewer finds that 5 units of 97545 and 30 units of 97546 are medically necessary for the week of work conditioning/hardening provided on the following dates: 2/19/07, 2/20/07, 2/21/07, 2/22/07 and 2/23/07.

The reviewer finds that 19 units of 97545 and 112 units of 97546 are not medically necessary, for the weeks of work hardening/work conditioning provided from 2/26/07-3/30/07.

PATIENT CLINICAL HISTORY [SUMMARY]:

The injured employee was involved in an occupational injury on XX/XX/XX. The injured employee was injured when he was getting off his stilts, lost his balance, and inverted his right ankle and fractured the distal fibula. The right ankle was placed in a cast. The fracture site was apparently misaligned and did not heal properly.
The injured employee underwent advanced diagnostic imaging and was placed on a bone growth stimulator. The injured employee underwent physical therapy with active and passive care. The injured employee underwent psychological assessment on 12-21-2006 by and recommendations were made for a work hardening program. The injured employee was placed in a work hardening program from 1-29-2007 through 3-30-07. On 3-27-2007 the injured employee underwent a designated doctor exam who reported that the injured employee was not at MMI and was not able to work.

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

It is noted by the reviewer that the facility performing the work hardening program in dispute is a CARF certified facility. In review of the documentation submitted, the injured employee met the criteria for the first 2-weeks of work hardening/conditioning, but these two weeks (1/29/07-2/2/07 and 2/5/07-2/9/07) are not in dispute in this review according to the documents submitted. See below: **Criteria for admission to a Work Hardening Program** #1 through #5. The admission criteria state that treatment should not exceed 2 weeks without demonstrated efficacy, subjective and objective gains, see Work Hardening ODG.

In this particular case, the documentation, FCE, PPE, medical reports, daily SOAP / progress notes do demonstrate efficacy needed for an additional 2-weeks of work hardening. These weeks include the periods 2/12/07-2/16/07 and 2/19/07-2/23/07. The latter week is the only week that is under dispute in this retrospective review. The reviewer finds that this fourth week of work conditioning/work hardening (2/19/07-2/23/07) was medically necessary and therefore partially overturns the previous adverse determination for this one week only. According to the billing records, this week included 5 units of 97545 and 30 units of 97546.

The reviewer finds that the remaining weeks of work hardening/work conditioning that are in dispute, which cover the period 2/26/07-3/30/07, and include 19 units of 97545 and 112 units of 97546, are not medically necessary.

The program timeline per ODG states that Work Hardening Programs should be completed in 4 weeks consecutively or less, see below #5 **Criteria for admission to a Work Hardening Program**. Medical documentation does show minimal patient progression. However, the extensive documentation provided for this retrospective review does not provide medical necessity outside the ODG.

It is noted that the facility performing the work hardening program is a CARF certified facility. See below the Q&A from the Department of Insurance explaining CARF exemptions: These rules state that work hardening services provided outside of the ODG criteria and without obtaining preauthorization can be denied by the insurance carrier as "payment denied/reduced for absence of precertification/authorization". Work Hardening services provided within the ODG guideline criteria but without obtaining preauthorization may be subject to retrospective review for medical necessity, and reimbursement may be denied based on lack of medical necessity. Additionally, preauthorization is required for any service, including Work Conditioning and Work Hardening programs, when the service is not specified as "recommended" by the ODG for a specific diagnosis, or when the service exceeds the number or duration listed in the ODG.

ODG Admission Criteria: Work conditioning / work hardening

Work conditioning, work hardening	Recommended as an option, depending on the availability of quality programs. 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. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. 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 conditioning program specific to the work goal may be helpful. (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. Work conditioning and work hardening are not intended for sequential use. They may be considered in the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work

conditioning may be less likely to be effective than work hardening or interdisciplinary programs. (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. **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 with job demands that exceed abilities, 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 consecutively or less. **ODG Physical Therapy Guidelines – Work Conditioning** 10 visits over 8 weeks See also Physical therapy for general PT guidelines.

Fracture of tibia and fibula (ICD9 823)
Medical treatment: 30 visits over 12 weeks
Post-surgical treatment (ORIF): 30 visits over 12 weeks

Fracture or Dislocation [ICD-9 Codes: 823.2X, 823.3X, 824.X, 837.X, 928.21]

A. Definitive Evaluation

Record a history of the cause of the injury.

Search for any evidence of an open wound in the vicinity of the fracture.

Perform a clinical examination for deformity, tenderness, or ecchymosis or associated nerve, neurovascular, or tendon injury.

Evaluate for evidence of joint instability.

Search for any evidence of dislocation or arterial vascular compromise (cold, dusky foot with loss of sensation), pulse and possibly sensation. If found, an immediate reduction should take place (prior to x-rays if necessary).

Perform an evaluation for an associated injury of the foot.

X-ray the ankle (two views). Special views such as mortise should be obtained when necessary. [Refer to the Ottawa Ankle Rules (Stiell, 1994)]

For detailed imaging criteria, see:

- Indications for imaging -- Plain Films (Radiography: AP, lateral, etc.)
- Indications for imaging -- MRI (Magnetic resonance imaging)
- Indications for imaging -- Bone Scan (Radioisotope Bone Scanning)
- Indications for imaging – Ultrasound

B. Initial Therapy

Simple, undisplaced stable fractures with no component of the fracture at the level of the ankle mortise (the gliding joint between the distal ends of the tibia and fibula and the proximal end of the talus) can be treated by the primary care physician.

1. A trilateral splint should be applied initially for two to three weeks. The patient will need crutches and should avoid weight bearing. Swelling is controlled with constant elevation above the heart.

2. Ice and elevation for 24-48 hours is appropriate.

3. Post fracture, two to three weeks (after the swelling has subsided), it is appropriate to apply a fiberglass cast with the foot at 90°. This allows the addition of a shoe for conversion to a walking cast one to three weeks after the cast has been applied. When casting, consider checking for vasomotor and sensory compromise. Weight-bearing is progressed to 50% with crutches until six weeks post injury when full weight-bearing is allowed and crutches are discontinued.

4. Analgesics for up to two weeks are appropriate, but in treating fractures, NSAIDs may be associated with side effects that are deleterious to treatment outcome, including delayed bone healing. Pain is usually due to swelling, and is best controlled with elevation of the ankle and foot. An initial IM pain injection is often indicated.

5. The patient should be rechecked seven to ten days after the fracture, seven to ten days after beginning partial weight-bearing, and after progressing to full weight-bearing.

6. X-rays are repeated during the above visits, and after the cast is removed at six weeks.

7. Physical therapy (one to five visits) to teach patient range-of-motion and muscle-strengthening exercises may be needed after cast removal.

8. If using a removable cast, starting at four weeks the patient should be allowed to begin gentle range-of-motion exercises with the cast off.

9. Prescribe level of activity at work and job modifications at each visit.

Nondisplaced, bimalleolar fractures should be referred to an orthopedic surgeon, as they are potentially unstable.

All other ankle fractures should be referred to an orthopedic surgeon. Compound fractures, when appropriate, should have a tetanus toxoid injection before being referred to an orthopedic surgeon.

C. Secondary Evaluation for patients with persistent symptoms or minimal improvement after six weeks of therapy

Review for compliance of the employee and employer to therapy programs and job modifications and restrictions. Also review for insurance company cooperation.

Evaluate for delayed union, malalignment, or signs of associated tendon or nerve injury or signs of reflex sympathetic dystrophy (CRPS I).

Promptly refer to an orthopedic surgeon if one of these conditions is found, otherwise continue therapy.

Refer to specialist needs to be considered before six weeks for conditions like Compartment syndrome.

WORK CONDITIONING & WORK HARDENING, ODG AND PREAUTHORIZATION PROCESS Q&As

1. Prior to the adoption of the Division's treatment guidelines [the Official Disability Guideline (ODG)], facilities accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) could request exemption from preauthorization for Work Conditioning and Work Hardening programs. Is this Division exemption still available for these programs?

Yes, facilities with CARF accreditation for Work Conditioning and Work Hardening programs may still request exemption from preauthorization. Facilities granted exemption status are listed on the Division website: Work Hardening and Work Conditioning Programs Exempted from Preauthorization and Concurrent Review (see: http://www.tdi.state.tx.us/wc/mr/carf-table.html).

2. Are there circumstances when the exempted CARF facilities are required to obtain preauthorization prior to rendering Work Conditioning and Work Hardening services?
Yes. Preauthorization is required for any service, including Work Conditioning and Work Hardening programs, when the service is not specified as "recommended" by the ODG for a specific diagnosis, or when the service exceeds the number or duration listed in the ODG.

3. When exempted CARF facilities do not obtain preauthorization prior to providing Work Conditioning or Work Hardening services within the ODG guideline criteria, can the services rendered be subject to retrospective medical necessity review by carriers?
Yes. Work conditioning and Work Hardening services provided within the ODG guideline criteria but without obtaining preauthorization may be subject to retrospective review for medical necessity, and reimbursement may be denied based on lack of medical necessity.

4. When exempted CARF facilities do not obtain preauthorization prior to providing Work Conditioning or Work Hardening services that are outside the ODG guideline criteria, should the services rendered be subject to retrospective medical necessity review by carriers?
No. Work Conditioning and Work Hardening services provided outside of the ODG criteria and without obtaining preauthorization should be denied by the insurance carrier as "payment denied/reduced for absence of precertification/authorization".

5. Currently, the ODG Procedure Summary has a category called "Work Conditioning, Work Hardening"; however, when seeking the criteria for Work Conditioning within that category, the text cross references to the "Physical Therapy" category. Therefore, is Work Conditioning the same as Physical Therapy, and should Work Conditioning be limited in number and duration to any unused Physical Therapy sessions?
No, Work Conditioning should not be confused with Physical Therapy. For Division purposes, Work Conditioning programs are defined as General Occupational Rehabilitation Programs in the CARF manual, and are designated with CPT Codes 97545 or 97546 and modifier "WC" when billing. Any previous Physical Therapy should not preclude approval, number of sessions, duration or reimbursement of a Work Conditioning program. However, the recommended number and duration of sessions for a Work Conditioning program should not exceed the recommended number and duration of sessions for Physical Therapy.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**