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Notice of Independent Review Decision

DATE OF REVIEW: September 3, 2008

Amended 09/05/08

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 doctor, 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 hardening program times 10 days/sessions

REVIEW OUTCOME

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

Overtured (Disagree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.
- o April 23, 2008 through July 24, 2008 reports and work status report from , D.O.
- o March 26, 2008 through March 27, 2008 records from .
- o June 13, 2008 lumbar MRI and cervical MRI reports signed by , M.D.
- o July 30, 2008 denial for work hardening that is not signed
- o August 18, 2008 physician review request by , M.D.
- o July 30, 2008 peer review report from
- o August 18, 2008 peer review report from
- o August 8, 2008 authorization request from
- o August 18, 2008 environmental intervention sheet from
- o July 25, 2008 work hardening preauthorization request from
- o April 25, 2008 initial behavioral medicine consultation from
- o July 18, 2008 functional abilities and evaluation report from
- o July 24, 2008 history and physical work hardening report from , D.O.
- o July 17, 2008 multidisciplinary work hardening report from
- o June 10, 2008 bilateral knee MRI report signed by , M.D.
- o May 17, 2008 through May 21, 2008 surveillance report by case manager
- o March 27, 2008 through April 1, 2008 work status reports by , M.D.
- o May 12, 2008 designated Dr. evaluation report by D.C.

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records, the patient sustained an industrial injury on xx/xx/xx involving the cervical spine, lumbar spine, bilateral knees, head, and bilateral knuckles. A request was submitted for work conditioning and a non-certification was rendered on July 30, 2008. The rationale provided was that the FCE submitted demonstrated submaximal/invalid effort. Lifting abilities demonstrated a clear submaximal ability. The injured worker had been reportedly observed during surveillance to lift much greater weight than demonstrated during the FCE. There was no evidence that light/modified duty was not available by the employer.

A letter dated August 8, 2008 from the provider was submitted. The letter states that the providers could not comment on the video but only on the FCE and what the treating doctor has reported. The patient's job level was noted to be very heavy while his current safe work capacity was light-medium. The patient did not meet multiple very heavy level job requirements as defined by the job description provided by the employer. The employer did not offer light duty employment for his job as a . He must lift 100 pounds with a frequent lift of 40-50 pounds. He lifts boxes, mattresses, tables, and chairs. The letter states that the patient completed a course of physical therapy between May and June 2008. An MRI on June 9, 2008 revealed minimal cervical spondylosis. An MRI of the right knee on June 11, 2008 revealed minor degenerative changes at the patellofemoral and tibiofemoral articulations; small knee joint effusion; mild signal intensity abnormalities of the hyaline cartilage, suggestive of chondromalacia; and focal blurring and irregularity of the articular margin of the medial tibial plateau. An MRI of the left knee on the same date revealed minor degenerative changes at the patellofemoral and tibiofemoral articulations; a small knee joint effusion; and mild signal intensity abnormalities of the hyaline cartilage. A June 16, 2008 lumbar spine MRI revealed very slight convexity of the lumbar spine on the left and mild disc degeneration and desiccation of the lumbosacral junction with slight posterior disc bulging of that disc margin. He completed six sessions of individual psychotherapy with the provider's offices in an effort to resolve injury related mood disturbance, implement coping skills, and improve his overall level of adjustment. His treating doctor requested that the patient be progressed to a multidisciplinary return to work program given his response to previous treatment. The letter lists several psychological measures that demonstrated improvement between April 25, 2008 and July 16, 2008. However the letter states that he has failed to achieve the targeted goal of 75% reduction in symptoms. The treatment team agreed that a multidisciplinary level of care with a behavioral group therapy component was in order. A strong component of his program will focus on resolving any vocational barriers that may exist. He has reached a plateau in outpatient physical therapy. He reportedly has a targeted job to return to an agreed upon vocational goal. According to the letter, he is likely to meet the very heavy PDL with this program.

The records also include an August 18, 2008 note that responds to the portion of the peer review report regarding surveillance. The videotape apparently showed the patient lifting a child and doing yard work. In response, the letter states that the patient is shown to lift between 21-28 pounds and his child is conceivably within this range. It was not clear what type of yard work the patient had performed. The letter states that if the patient was taped mowing or raking his yard, this would be consistent with his current capabilities. Patients are urged to resume or continue many of their normal activities.

The case was again reviewed on August 18, 2008 and another non-certification rendered. The rationale listed included no reliable job requirements/ability mismatch demonstrated. The performance on FCE was submaximal effort and inconsistent with clinical condition. Imaging studies were noted to be essentially negative. There was no significant pathology present. The disability exceeded the MDA parameter. Surveillance indicated ability exceeded the FCE. There was no evidence that the program would include job simulation. It was noted that the request did not meet the ODG criteria.

The records include a July 18, 2008 Functional Abilities Evaluation report. The patient tested positive on two of seven W addell signs which was found to be clinically insignificant. He was found to have significant disability upon questioning on the Oswestry form and the Neck Disability Index. The patient lifting and strength measurements were carefully reviewed and there is no evidence within the FCE report that the patient demonstrated submaximal effort.

A May 17, 2008 through May 21, 2008 surveillance report was submitted for review. The report does indicate that the patient lifted his approximately 3-year-old daughter on multiple occasions. The report does not include an estimate as to her weight. He was described as a male standing approximately 5 foot 7 and weighing approximately 190 pounds. The surveillance video report does state that the patient was observed mowing his front lawn with activity including pushing and pulling a manual mower.

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

As noted above, the FCE a report dated July 18, 2008 does not include evidence that the patient demonstrated submaximal effort during strength testing. His job requires a very heavy physical demand level, while he tested at a light-medium level. The records include appeal letters which state that based on the results of the FCE, the patient should be able to lift a child weighing between 21 and 28 pounds. His job description states that he must lift up to 100 pounds and frequent lifting of 40-50 pounds. He is noted to have reached a plateau in outpatient physical therapy. While he demonstrates positive findings upon imaging, in particular the bilateral knee MRIs, he is not a clear surgical candidate. Given these factors, he meets the criteria specified by the Official Disability Guidelines for admission to a work hardening program. The quantity requested is appropriate for these guidelines as well. Therefore, my determination is to overturn the decision to non-certify the request for a work hardening program times 10 days/sessions.

The IRO's decision is consistent with the following guidelines:

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
- ___X___ 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 (2008)/Lumbar Chapter:

Work conditioning, work hardening:

Recommended as an option, depending on the availability of quality programs. Physical conditioning programs that include a cognitive-behavioural 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 therapy provider 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) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-Cochrane, 2008) Use of Functional Capacity Evaluations (FCE's) to evaluate return-to-work may show mixed results. See the Fitness For Duty Chapter.

Criteria for admission to a Work Hardening Program:

- (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA).
- (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.
- (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.
- (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
- (5) 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
- (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with 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.
- (7) 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.
- (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less.
- (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities.
- (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Physical Therapy Guidelines - Work Conditioning

10 visits over 8 weeks

See also Physical therapy for general PT guidelines.

And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.

The Official disability Guidelines neck and upper back chapter refer the reader to the low back chapter for additional details of references.

Official Disability Guidelines (2008)/Knee Chapter:

Work conditioning, work hardening:

Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. (Schonstein-Cochrane, 2003) There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. (Karjalainen, 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) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-Cochrane, 2008)

Criteria for admission to a Work Hardening Program:

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- (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.
- (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.
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ODG Physical Therapy Guidelines - Work Conditioning

12 visits over 8 weeks

See also Physical therapy for general PT guidelines