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Notice of Independent Review Decision

DATE OF REVIEW: November 19, 2009

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 Chiropractor, Licensed in Texas. 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

REVIEW OUTCOME

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

Upheld (Agree)

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 03-29-08 Initial exam notes for DOI 3-27-08 fall, signature illegible
- o 03-31-08 Examination notes, unsigned
- o 03-31-08 X-ray report from Dr.
- o 04-07-08 Visit notes from illegible
- o 04-14-08 Visit notes from illegible
- o 04-08-08 Work Status Report from Dr.
- o 06-29-09 Initial report
- o 07-01-09 Med-Cure progress notes, 12 pages through 10-20-09, 8 dates of service
- o 08-13-09 Examination report from Dr.
- o 09-14-09 Medi-Cure progress notes -
- o 10-02-09 Preauthorization report (microprint)
- o 10-15-09 Reconsideration Preauthorization report (microprint)
- o 10-26-09 Functional Abilities Evaluation from Dr.
- o 10-26-09 Medical report from Dr. (DD exam)
- o 11-05-09 Request for IRO from the provider
- o 11-06-09 Confirmation of Receipt Request for IRO from TDI
- o 11-09-09 Case Assignment for IRO from TDI

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews, the patient is a female who sustained an industrial injury to the head, neck and upper back on xx/xx/xx when she tripped over a buffer cord and fell backwards over the buffer machine. She was recommended to undergo 18 sessions of PT on July 9, 2009 and Motrin was refilled.

The medical records indicate that the patient was treated for a prior industrial injury to the neck, shoulder and right knee associated with a fall on March 27, 2008. On March 31, 2008 she reported weakness in the hands and neck pain that radiates to both shoulders as well as knee pain. Cervical x-rays showed no acute changes. On April 14, 2008 she was noted to be much improved.

The patient was examined on June 29, 2009 after a fall. Handwritten treatment notes are reviewed: She complains of headache, neck pain and low back pain. She is diagnosed with strain to the cervical and lumbar spine. She was ordered PT and Motrin. On July 9, 2009, the patient reported she is much better. She continues to have tenderness at the neck and restricted cervical range of motion. MRI results were explained to the patient. On July 20, 2009 the patient reported left lower extremity symptoms and the notes indicate EMG findings were abnormal. She will have a neurosurgical evaluation and PT will be discontinued.

The patient was provided a specialty consultation on August 13, 2009. She reports neck pain with no weakness, numbness or pain extending into the arms. She has low back pain that extends into the left leg to the proximal calf. She has been treated conservatively. She is 5' 4" and 181 pounds. There is slight restriction of cervical ROM and slight muscle spasm with normal sensation and motor strength noted. Shoulder motion is full with pain noted with full external rotation and abduction. The lumbar spine exam was essentially unremarkable other than slight restriction of motion and 1+ muscle spasm noted. MRIs and nerve studies were recommended.

Handwritten physician progress notes are reviewed: The patient reports she is better with meds. She reports low back pain and headaches. She saw an orthopedic specialist and he recommended a work hardening program and follow-up in pain management for possible injection. As she has not yet initiated PT, a work hardening program will begin as soon as possible. She still needs a head CT. She has not returned to work (08-18-09). She is 5' 5" and 185 pounds. She was referred for PT at 2-3 times weekly. She reports sleep difficulty. She is wearing a back brace. She has been returned to light duty work (09-14-09). She comes in for her two-week re-check. She was ordered light duty but was made to work full duty. She only worked one day due increased pain. The patient states she called 1.5 weeks ago to see if work hardening had been approved. She was told to wait for a call which still has not come. She was told the CT scan was not approved. She needs PT-Work Hardening (09-29-09). She reports headache, neck and low back pain. She is tender at the neck with palpation of 4/10 level pain. She states PT-work hardening has been denied. Still no CT scan yet. She is scheduled for a Designated Doctor exam on October 26, 2009 set up by the carrier. She is prescribed Soma 350 mg (10-20-09).

The patient underwent a Functional Abilities Evaluation on October 26, 2009. She has normal posture and gait. She can squat and climb stairs. She was unable to kneel reportedly due low back pain. Cardiovascular testing of Astrand and Kasch step test were both invalid due stopping the test due to reported low back pain; final heart rates were 94 and 84. Generalized neurological testing did not show sensory deficit. Neck and low back ROM are limited. Generalized muscle/myotomal strength testing did not detect gross motor deficit. Hand grip showed very limited grip strength bilaterally with suggestion of submaximal effort noted. Overall, testing was inconsistent, the examinee provided submaximal effort limited and terminated by the examinee's reported pain. She demonstrated inconsistent effort with pinch strength testing. She demonstrated ability to push 24.7 pounds, pull 16.7 pounds, leg lift 20.8 pounds, arm lift 16.8 pounds and high near lift of 15.1 pounds with consistent effort noted. Summary states overall inconsistent and submaximal effort. She reports her PDC is medium.

A Designated Doctor exam was conducted on October 26, 2009. She has been using ibuprofen for pain and Amrix for sleep. MRI of July 6, 2009 shows a disc herniation at C5-6. There are lumbar disc herniations at L3-4, L4-5 and L5-S1. The initial impression was cervical and lumbar strain injuries. Cervical flexion is 34 degrees and extension 38 degrees. Motor strength is normal in the upper extremities and neck. Left shoulder adductor strength was graded as 4/5; however specific muscular exam related to the site of injury showed no abnormalities. Gait is normal. She can walk on her heels and toes. Squatting is normal. There is no tenderness noted with palpation in the lumbar, pelvic and sacral regions. Straight leg raise in seated and supine are normal. Lumbar flexion is to 20 degrees and extension to 12 degrees. Back and lower extremity motor strength is normal. Waddell's: two out of eight are positive which is not significant for symptom magnification. Diagnosis is cervical strain, lumbar sprain and low back pain with sciatic nerve irritation. She is MMI as of today with 10% whole person impairment. Her functional testing was, overall, inconsistent and showed submaximal effort. She is at an indeterminate PDC.

Request for work hardening was considered in review on October 2, 2009 with recommendation for non-certification with rationale that the treatment to date has been limited and all lower levels of care have not been exhausted.

Request for reconsideration of work hardening was considered in review on October 15, 2009 with recommendation for non-certification as she has been determined to be MMI and work hardening is not clinically indicated.

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

In August 2009, the patient is noted to have slight restriction of cervical ROM and slight muscle spasm with normal sensation and motor strength. The lumbar spine exam was essentially unremarkable other than slight restriction of motion and 1+ muscle spasm. The patient had not initiated PT and a work hardening program was recommended in a specialty consultation. A functional capacity evaluation showed inconsistent and submaximal effort and the patient's work capacity remains indeterminate. She has been deemed MMI with 10% whole person impairment. ODG criteria 4 and 5 have not been met: (4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical

demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. (5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

On this basis, my recommendation is to agree with the prior non-certification of the request for work hardening.

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
- 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

The Official Disability Guidelines - Lumbar Chapter (11-13-2009) - Work Conditioning/Work Hardening:

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, rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. See also Return to work, where the evidence presented for "real" work is far stronger than the evidence for "simulated" work. Also see Exercise, where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job

Criteria for admission to a Work Hardening (WH) Program:

- (1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.
- (2) Screening Documentation: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of

injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.

(3) 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).

(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.

(6) Rule out surgery: The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).

(7) Healing: 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.

(8) 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.

(9) 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.

(10) Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.

(11) Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should be documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.

(12) Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.

(13) Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.

(14) Trial: 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 improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.

(15) Concurrently working: The patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.

(16) Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.

(17) Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.

(18) 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. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).

(19) Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.

(20) Discharge documentation: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) Repetition: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.