



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 10/28/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Work hardening 5 x wk x 2 wks cervical

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

Texas Licensed Psychologist

REVIEW OUTCOME

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

Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

1. CT of the cervical spine dated 01/27/09
2. Follow up note dated 05/06/09
3. Partial mental health evaluation dated 05/07/09
4. Electrodiagnostic study dated 05/21/09
5. Decision and order dated 07/08/09
6. Follow up note dated 07/30/09
7. History and physical for the work hardening program dated 07/30/09
8. Functional capacity evaluation dated 08/07/09
9. Employee job description/employer contact form dated 08/19/09
10. Preauthorization request dated 08/21/09
11. Work hardening program preauthorization request dated 08/21/09
12. Previous review dated 08/26/09
13. Reconsideration dated 09/17/09
14. Previous review dated 09/23/09
15. **Official Disability Guidelines**

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is xx/xx/xx. On this date, the employee was sitting in his work truck which was stopped at a signal light when he was rear-ended. The employee was "fine" until approximately four days later when he began to experience pain in his neck going down into his arms.

The employee underwent a CT scan of the cervical spine on xx/xx/xx which revealed postsurgical changes from cervical fusion from C3-C6 with a plate affixing the C5-C6 vertebral bodies anteriorly.

A follow-up note dated 05/06/09 indicated the employee underwent ACDF in 2006 which was exacerbated by the injury of xx/xxxx. The employee complained of pain in the neck going down his arms.

The submitted records contain a portion of a mental health evaluation performed on 05/07/09. The employee reportedly underwent L3-L4 and L4-L5 laminectomy on 03/31/09. Medications were listed as Darvocet, Flexeril, Lodine, and Lyrica. The employee reported more conflict with his family, less involvement in family activities, isolation from others, and feeling abandoned by co-workers. The employee endorsed sleep maintenance insomnia. Mood was dysthymic and anxious, and affect was constricted and appropriate to content. The diagnosis was adjustment disorder, acute, with mixed anxiety and depressed mood secondary to the work injury. The remainder of the evaluation is not submitted for review.

The employee subsequently underwent EMG/NCV study on 05/21/09 which revealed bilateral carpal tunnel syndrome.

The employee underwent a history and physical for a work conditioning program on 07/30/09. Treatment to date included CT scan, MRI, EMG/NCV, and medication management. The employee had not undergone physical therapy. The impressions were listed as exacerbation of previous ACDF from C3 through C6 and bilateral cervical radiculopathy. The employee was recommended to continue his work status and was recommended for participation in a work hardening program.

The employee underwent a Functional Capacity Evaluation (FCE) on 08/07/09. The employee's current physical demand level was reported as medium/heavy and required physical demand level was very heavy.

A work hardening preauthorization request dated 08/21/09 indicated that the employee had completed a brief course of individual psychotherapy; however, there were no supporting progress notes provided. The employee denied any change in his depression, but he did report reductions in irritability, frustration, muscle tension/spasm, anxiety, sleep disturbance, and forgetfulness/poor concentration. The employee continued to demonstrate psychological overlay, and the employee was recommended to progress into a multidisciplinary return to work program. This evaluation reported that the employee "has reached a plateau in outpatient physical therapy"; however, previous records indicated that the employee had not undergone physical therapy as it was previously denied.

A previous request for work hardening was non-certified on 08/26/09 by D.O. Dr. noted that the information supplied "is not consistent with the conceptual basis for work hardening". There was a lack of evidence that the employee

had recovered to the extent his treatment had ended, and the only deficits that were preventing his return to work at full duty were functional limitations and deconditioning related to a prolonged period away from work. The information provided reportedly indicated that the employee continued to suffer from pain to the extent that a pain management specialist had been consulted which suggested that the employee would not sufficiently benefit from the proposed program.

An appeal for work hardening was previously non-certified per utilization review performed on 09/23/09 by Ph.D. Dr. noted that "it does not appear that this employee is capable of completing the rigorous requirements associated with a work hardening program at this time". There was no return to work goal agreed to by the employer and employee.

A reconsideration request dated 09/17/09 indicated that although a pain management referral was made, the insurance carrier denied coverage of this appointment, as well as for neurosurgical consultation and physical therapy. There was reportedly an absence of other options available to the employee. The employee reportedly completed twelve sessions of physical therapy with some improvement noted and had reached plateau.

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

Based on the clinical information provided, the two previous denials are upheld, and the request for work hardening 5 x wk x 2 wks cervical is not recommended as medically necessary. The employee sustained injuries in xx/xxxx which exacerbated a previous ACDF performed in 2006. The submitted records indicate that previous requests for physical therapy and neurological consultation were denied; however, the reconsideration request for work hardening reported that the employee previously underwent twelve sessions of physical therapy. There was no comprehensive assessment of treatment completed since xx/xxxx or the employee's response thereto to establish that the employee had undergone an adequate trial of active physical rehabilitation with improvement followed by plateau. Current evidence-based guidelines support participation in a work hardening program only with objective documentation that the employee has completed adequate lower levels of care with improvement followed by plateau. Additionally, there was no clearly defined return to work goal as required by the ***Official Disability Guidelines***.

Given the current clinical data, work hardening 5 x wk x 2 wks cervical is not indicated as medically necessary for this employee.

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

Official Disability Guidelines Neck and Upper Back Chapter

Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. See the [Low Back Chapter](#) for more details and references. There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. There is no evidence that work hardening for neck pain (reproduction of the work environment) is more effective than a generic strengthening program. The key factor in any program is the objective measurement of improving functional performance with base line and

follow-up testing. ([Karjalainen, 2003](#)) 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](#)) Work Conditioning should restore the injured worker'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. For more information and references, see the [Low Back Chapter](#). The Low Back WH & WC Criteria are copied below.

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 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.

ODG Work Conditioning (WC) Physical Therapy Guidelines

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). See also [Physical therapy](#) for general PT guidelines. 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.