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Notice of Independent Review Decision

DATE OF REVIEW: 11/06/09

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 (Board Certified), 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

97545/97546 Work Hardening Program x 10 days/Sessions Trial (5 x 2 weeks)

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 412 pages of medical records were submitted. After eliminating redundant reports, approximately 170 pages of records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO
- o 09-16-09 Inpatient medical treatment reports
- o 09-17-08 Doctors First Report of Injury, unsigned
- o 09-18-09 ER medical reports and imaging reports
- o 10-03-08 Medical report from Dr.
- o 10-06-08 Consultation report and treatment notes from Dr. 0-06-08 thru 10-21-08
- o 10-12-08 ER evaluation reports and lumbar x-ray
- o 10-16-08 Reevaluation report and treatment notes thru 11-07-08 from Dr.
- o 11-03-08 Initial Behavioral Medicine Consultation from Dr.
- o 11-14-08 Notice of Disputed Issues
- o 11-19-08 Chiropractic treatment notes from Dr. through January 30, 2009
- o 01-13-09 Reevaluation report from Dr.
- o 02-04-09 Treatment notes through May 7, 2009 from Dr.
- o 05-13-09 Investigation Results from Investigative Group
- o 06-18-09 Initial history and physical from Dr.
- o 06-24-09 Follow-up report from Dr.
- o 07-14-09 Initial Behavioral Medicine Consultation from LPT-Intern
- o 08-05-09 Environmental Intervention from Ph.D.
- o 08-07-09 Notice of Suspension of income benefits
- o 08-27-09 History and Physical for the WH Program from Dr.
- o 08-28-09 FCE from DC
- o 09-01-09 Employee Job Description from Dr.

- o 09-04-09 WH Program Pre-Authorization from MS, CRC, LPC
- o 09-10-09 Initial Adverse Determination Letter
- o 09-15-09 Designated Doctor Evaluation, unsigned
- o 09-24-09 Reconsideration-WH Program Pre-Authorization from MC, CRC, LPC
- o 09-25-09 Follow-up Report from Dr.
- o 10-01-09 Adverse Determination Letter for reconsideration
- o 10-16-09 Request for IRO from claimant
- o 10-19-09 Confirmation of Receipt of IRO from TDI
- o 10-20-09 Notice of Assignment of IRO from TDI
- o 10-22-09 IRO Summary

PATIENT CLINICAL HISTORY [SUMMARY]:

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the low back on xx/xx/xx when lifting . She woke up the next day with soreness and then "threw out' her back on xx/xx/xx.

The patient was seen at a local hospital on xx/xx/xx. She arrived via ambulance and transferred herself to a gurney. She reported pain when picking up an object. She was examined and provided a diagnosis of back sprain. An injection of Zofran and Nubain and oral Vicodin were provided and she was discharged.

According to an outpatient physician examination report if September 18, 2009 the patient is reporting neck, mid back and low back pain with radiation of pain into the right leg. She is 5' 5" and 242 pounds. Radiographs and MRI are planned. Cervical x-rays are given impression of poor visualization of C6 and C7 due to overlying soft tissues with no significant osseous pathology appreciated. Thoracic x-rays are significant only for pectus excavatum anomaly of the anterior chest wall. Lumbar x-rays show "no significant pathology noted involving the lumbar spine."

The patient returned to the hospital on September 20, 2009. She tried to pick up her daughter's clothes and thinks she re-injured her back. It was determined she could return to work.

On September 23, 2008 the patient reports no relief with hydrocodone and ibuprofen. She wants a muscle relaxant and an additional work restriction to sit when she desires. She is started on Baclofen.

Lumbar MRI of September 30, 2008 was provided impression of small left subarticular zone disc protrusion L5-S1 level adjacent to the originating left S1 nerve root. This MRI was not certified retroactively in review on November 6, 2008.

On October 3, 2008 the patient complains of difficulty picking up her 17-pound daughter. She complains of pain into the legs and occipital pain. She is nursing her child and seeks pain control. She was taking Baclofen, hydrocodone and Skelaxin, but that caused drowsiness and she fell asleep at work and was reprimanded and suspended. She can continue work with restrictions.

The patient was examined chiropractically on October 6, 2008 by an approved new treating provider. Hypesthesia is noted in the L5 distribution. Chiropractic treatment was initiated and the patient was subsequently provided 58 visits.

The patient was sent for a consultation on October 8, 2008. This appears to be a pain management consultation. The patient was advised to stop breastfeeding.

Chiropractic treatment notes of October 10, 2008 indicate the patient is not responding to treatment. The patient presented to ER on October 12, 2008 complaining of back pain and numbness in the legs since bending over her daughter's crib. A Toradol injection was provided. X-rays showed a grade I retrolisthesis of L5 on S1 of 5 mm. Otherwise no significant degenerative disc disease was seen. Only very slight facet arthrosis was seen. Chiropractic notes of October 13, 2008 note the patient is not responding to treatment. Notes of October 21, 2009 note the patient's pain level has increased with treatment.

Chiropractic in-house NIOSH testing was conducted on October 16, 2008 and the patient was reportedly functioning at a sedentary physical demand level and had indications of minimal depression and mild anxiety. Recommendation was made for a psyche consultation. Treatment notes through November 7, 2008 indicate the patient is not improving with treatment and is sometimes better and sometimes worse.

A Behavioral Medicine Consultation was provided on November 3, 2008. The patient was treated in Occupational Medicine and was not happy with their services and transferred to a chiropractic provider. She has been referred for a surgical consultation. She denies previous illness, injuries, or operations that could have contributed to her current symptomatology. She saw a counselor in her late teens and has previously been prescribed Paxil, Depacote, Prozac, and Ritalin. She is not married and has 2 children. Recommendation is made for individual psychotherapy treatment.

The patient continued chiropractic treatment at three times per week. Most of the treatment notes covering November 17, 2008 through January 30, 2009 indicate no change or patient worse.

The patient was reevaluated chiropractically on January 13, 2009. Questionnaires indicated evidence of mild anxiety and moderate depression and misuse of alcohol, prescribed medications, and other substances for the management of pain. There may be a somatic preoccupation that requires additional evaluation. She has been referred for a surgical consultation. Chiropractic treatment notes covering February 4, 2009 through May 7, 2009 (9 visits) generally state the patient's condition is

about the same.

The patient underwent sub-rosa investigation in early May 2009. On May 11, 2009 the claimant was observed walking, driving and carrying large items. No walking aides were being used by the claimant.

The patient was examined initially by her current provider on June 18, 2009. She is using Vicodin and Baclofen. Her heel and toe walk is performed with extreme difficulty. She has decreased strength in both of her legs. She is prescribed Darvocet and Flexeril. On June 24, 2009 the provider opines the patient to have torn her annulus fibrosis of a lumbar disc when bending over and lifting. Recommendation is for nerve studies and a neurosurgical consultation. She is prescribed Lyrica.

An Initial Behavioral Medicine Consultation was conducted on July 14, 2009. She reports attending 10 sessions of PT. A repeat MRI of May 18, 2009 revealed mild degenerative changes at L5-S1 without stenosis. She reports stabbing back pain with a feeling of numbness in both legs rated as 6-8/10. She reports no record of mental disorders or emotional issues impacting her independent functioning prior to the injury of September 16, 2008. Her mood was elevated. She has Major Depressive Disorder and injury to the low back. Recommendation is for 6 weeks of individual psychotherapy.

A Designated Doctor Examination was conducted on July 15, 2009: The patient complains of constant pain in her low back with constant numbness and tingling below her knees to her toes. She says she is so bad she cannot fix her own hair and has trouble bending over and picking up her daughter. Her initial x-rays showed no pathology or any abnormality. An MRI of September 2008 showed a left disc protrusion with minimal osteophyte at L5-S1 with all else normal. No evidence of neurologic testing is found. She saw an orthopedic surgeon, but no surgery has been recommended. She is using about 5 Vicodin daily, two Skelaxin and baclofen and Darvocet of a couple every other day. She has an upcoming appointment with a neurologist. Her gait and posture appear normal. She had some unexpected responses to parts of the evaluation. She had a hypersensitivity to light touch over the lumbar spine region. She reported increased low back pain while in the standing position applying pressure down on the top of her head. Her stiff leg raise tests were inconsistent in the seated and standing positions. These are all considered to be multiple Waddell signs. Her numbness did not follow any radicular or neurologic pattern. Her muscle strength appears to be 5/5 in all groups. She appeared to be guarding against reflex testing. Her diagnosis is lumbar strain and low back pain. She is MMI. She has zero impairment. She needs to return to work. Her physical exam and findings are consistent enough to document that she has no significant pathology or limitation. She could return to work without restrictions.

According to a psychological opinion of August 5, 2009 the patient is too young to risk surgery and because her reports of pain, functional impairment and failure to return to work are inconsistent with the extent of injury, there is suggestion of a psychological overlay that has yet to be addressed.

The provider submitted a History and Physical for Work Hardening program report on August 27, 2009. The patient continues to report pain and discomfort in her back. She would be an excellent candidate for the work hardening program. She needs a multidisciplinary return to work program.

An FCE was conducted on August 28, 2009. A heart rate monitor was used to assess effort. She is able to function at a light job demand level and her job requires a medium demand level. The heart monitor reveals a heart rate of 82 following cardiovascular testing versus 89 at rest prior to testing. With lifting, the patient's resting heart rate was 87 bpm and remained at 87 bpm following testing. With dynamic lifting the patient's heart rate remained at 89 bpm before and after testing. With dynamic carrying the patient's heart rate remained at 89 bpm before and after testing.

Work Hardening was requested on September 4, 2009. Individual psychotherapy has been requested but not authorized. However, this is not to suggest that she does not have active psychological overlay as a result of pain and loss of functioning. She is unable to safely perform required work tasks. She needs a program to address remaining functional deficits. The employer will allow return to work if she has a Medium PDL. Her FCE indicates she is able to work at a Light PDL. She would need to lift bags of groceries and grocery items weighing 10-25 pounds frequently and up to maximum 50 pounds according to her job description.

Request for Work Hardening program 5x/week for two weeks; 10 day trial was considered in review on September 9, 2009 and recommended for non-certification. Rationale for non-certification noted the patient is a cashier, which is a light duty position. She is reportedly at a light physical demand level with no documented return to work. The employer accommodates modified duty and there are no objective barriers to return to work. In peer discussion, the provider determined she cannot safely return to work, an opinion which does not have a scientific basis. It was explained that the employer accommodates modified work, the patient's job is light to light medium and based on her FCE she should be able to return to her regular work. According to her My Space, the patient is very social and active.

Request was made for reconsideration on September 16, 2009. The employer notes the maximum lifting requirement is occasional lifting to 50 pounds, which would require the patient to function at a Medium PDL, not a light to light medium PDL. There has been no bona fide job offer for a modified/light duty position provided by the employer. The My Space photos are not

date stamped.

Request for reconsideration was considered in review on October 1, 2009 and recommended for non-certification. Per the reviewer, if the claimant is released from care to full duty, there does not need to be a bona fide job offer. Additionally, the FCE is not validated as there is no change in heart rate seen on various lifts. Per DDE opinions of 07-15-09, the claimant should return to full duty work. She has zero impairment and the effects of the injury have resolved. Continued supervised treatment in this case serves only to further iatrogenic debility, disability and lost time from gainful employment. There is a dispute for occupational benefits regarding compensability and/or extent of injury. In May 2009 sub rosa report notes, the patient walking, driving and carrying large items.

According to a summary from the carrier, the patient voluntarily terminated employment on August 17, 2009. She was assigned light duty by her provider on 10-08-09 and released to full duty per DDE opinions on July 15, 2009. The patient has a history of Depressive Syndrome and prior psychiatric hospitalizations.

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

The patient presented at emergency reporting back pain from lifting at work. X-rays were unremarkable. She was returned to work. Four days later she returned to emergency with report of back pain. She sought additional work restrictions. MRI reveals, a small left subarticular zone disc protrusion L5-S1 level adjacent to the originating left S1 nerve root. The patient worked light duty until November 8, 2008 when she voluntarily terminated her employment (per report of October 6, 2008 - she fell asleep at work and was reprimanded and suspended). The patient was not happy with occupational medicine management and initiated chiropractic treatment on October 6, 2008 and despite repeated reports of no improvement, 58 chiropractic sessions were provided through approximately May 7, 2009. After the first week of chiropractic the patient returned to the ER reporting back pain and leg numbness. X-rays showed a grade I retrolisthesis of L5 on S1 of 5 mm. Otherwise no significant degenerative disc disease was seen.

On November 3, 2008, the patient denied previous illness, injuries, or operations that could have contributed to her current symptomatology. She stated she saw a counselor in her late teens and has previously been prescribed Paxil, Depacote, Prozac, and Ritalin. Per the carrier, the patient has a history of Depressive Syndrome and prior psychiatric hospitalizations. Per a chiropractic report of January 14, 2009, there is evidence of mild anxiety and moderate depression and misuse of alcohol, prescribed medications, and other substances for the management of pain. There may be a somatic preoccupation that requires additional evaluation. Per a consultation of July 2009, repeat MRI of May 2009 revealed mild degenerative changes at L5-S1 without stenosis. She reports stabbing back pain with a feeling of numbness in both legs rated as 6-8/10. She reports no record of mental disorders or emotional issues impacting her independent functioning prior to the injury of September 16, 2008. Per a DD exam of July 2009 no evidence of neurologic testing has been found in the records. The patient exhibits multiple Waddell signs, her numbness does not follow any radicular or neurologic pattern and muscle strength appears to be 5/5 in all groups. Her diagnosis is lumbar strain and low back pain. She is MMI. She has zero impairment. She needs to return to work. Her physical exam and findings are consistent enough to document that she has no significant pathology or limitation. She could return to work without restrictions. An FCE of August 2009 remains invalid as there was no change in heart rate seen on various lifts.

The patient does not have any significant imaging findings. Nerve studies have not been reported to clarify any radiculopathy. The patient has a prior history of Depressive Syndrome and psychiatric hospitalizations. There is evidence of misuse of alcohol, prescribed medications, and other substances for the management of pain. The patient has been observed walking, driving and carrying large items. Per DD opinions, she exhibits multiple Waddell signs, her numbness does not follow any radicular or neurologic pattern and muscle strength appears to be 5/5 in all groups. Her physical exam and findings are consistent enough to document that she has no significant pathology or limitation. She could return to work without restrictions. The medical necessity for an extended multidisciplinary Work Hardening program is not substantiated. Per guidelines, these programs should only be utilized for select patients with substantially lower capabilities than their job requires. 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. 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). An FCE performed in August 2009 remains invalid as there was no change in heart rate seen on various lifts. Given that the patient is has been released to full duty, the clinical findings do not establish a medical necessity for work hardening.

Therefore, my recommendation is to agree with the prior non-certification for Work Hardening Program x 10 days/Sessions Trial (5 x 2 weeks).

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 (10-12-2009) 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 (see ODG Capabilities & Activity Modifications for Restricted Work), 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. 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 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. (Schonstein-Cochrane, 2003)

See also Chronic pain programs (functional restoration programs), where there is strong evidence for selective use of programs offering comprehensive interdisciplinary/ multidisciplinary treatment, beyond just work hardening. 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 (FCEs) to evaluate return-to-work require validated tests. See the Fitness For Duty Chapter.

Interdisciplinary Work-Related Exercise Approaches Adding Psychological Support: These approaches, called Work Hardening (WH) programs, feature exercise therapy combined with some elements of psychological support (education, cognitive behavioral therapy, fear avoidance, belief training, stress management, etc.) that deal with mild-to-moderate psychological overlay accompanying the subacute pain/disability, not severe enough to meet criteria for chronic pain management or functional restoration programs. (Hoffman, 2007) See also Chronic pain programs (functional restoration programs). There has been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition back to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to successful return to work. Types of issues that are commonly addressed include anger at employer, fear of injury, fear of return to work, and interpersonal issues with co-workers or supervisors. The ODH WH criteria are outlined 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): prior to treatment in these programs. 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
- (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.

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.