

INDEPENDENT REVIEWERS OF TEXAS, INC.

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Notice of Independent Review Decision

DATE OF REVIEW: 10/29/09

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: 10 sessions of work hardening for cervical and thoracic spine at Rehab Institute as requested by Dr.

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

Texas Board Certified Family Practice

REVIEW OUTCOME

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

Denial Upheld

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a male whose date of injury is listed as xx/xx/xx. Records indicate that the employee was injured secondary to a motor vehicle accident when he was rear ended by an SUV type vehicle while stopped at a red light. Radiographs of the thoracic spine done xx/xx/xx reported thoracic spondylosis with slight scoliosis but no acute fracture or dislocation.

Cervical spine radiographs on xx/xx/xx revealed somewhat pronounced cervical lordosis with no fracture or subluxation and minimal spondylitic changes. There was no soft tissue abnormality and examination was otherwise negative. MRI cervical spine dated 05/20/09 reported multi level cervical spondylitic change with slight retrolisthesis of C3 on C4 and C4 on C5. There is posterior osseous riding and disc bulge or protrusion at C3-4 and C4-5, with at least mild central spinal stenosis. Electrodiagnostic testing performed on 08/13/09 was reported as a normal study with no evidence of focal nerve entrapment, generalized peripheral neuropathy, plexopathy, radiculopathy, or central spinal stenosis.

A medical records/peer review report dated 07/23/09 by Dr. reported soft tissue myofascial strain which may not have fully resolved but would be expected to resolve by early 08/2009. The extent of injury was limited to a cervical soft tissue myofascial strain. Dr. noted that it would not be anticipated that ongoing additional treatment

including injections, surgery, chronic pain program, work hardening program or conditioning programs would be necessary.

A Functional Capacity Evaluation (FCE) dated 09/01/09 demonstrated the employee was at least able to occasionally lift 15 pounds from the floor, carry 15 pounds, and push/pull 15 pounds. Records indicate the employee was treated with physical therapy. The employee also underwent one cervical epidural steroid injection without improvement. Records also reflect the employee had Beck Depression Inventory score of 51 and Beck Anxiety Inventory score of 50.

A preauthorization request for ten sessions of work hardening for the cervical and thoracic spine was denied on 09/25/09. The reviewer noted that the request did not meet **Official Disability Guidelines** and an employer verified job description is required; the results of FCE were not validated as appropriate heart rate increases were not seen; work hardening programs where the employee was substantially lower capabilities than their job requires. The reviewer noted that FCE suggested the best treatment at this time would be full duty release.

A reconsideration request was reviewed and denied on 10/09/09. The physician advisor noted that FCE demonstrated the employee was at least able to occasionally lift 15 pounds from the floor, carry 15 pounds, and push/pull 50 pounds. The FCE evaluation did not demonstrate valid heart rates to confirm full effort. With the documentation in mind, a work hardening program was not indicated. The reviewer noted that the documents submitted for reconsideration indicated the employee was still considerably symptomatic which would be a contraindication for work hardening program as the high level of symptoms would interfere with the program.

Psy.D., indicated that the FCE reported the employee to present with significant radiculopathy into the right shoulder and that the employee was capable of sedentary light to medium physical demand level. He noted that the OTR who performed the FCE that the employee's heart rate was 59 at the beginning of evaluation and at 7 while the employee was lifting 15 pounds and that the employee stopped at 15 pounds due to increased pain. The OTR also pointed out the employee's cardiovascular abilities were at a sedentary level and did not meet the employee's job demand.

Medical notes from Dr. were noted to report the employee remained considerably symptomatic without significant relief of symptoms, but on examination there were negative sensory and motor findings as related to the cervical and thoracic areas.

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

Based on the clinical data provided, the request for ten sessions of a work hardening program for cervical and thoracic spine is not seen as medically necessary and previous denials should be upheld on IRO. The employee sustained an injury secondary to MVA on xx/xx/xx. The employee participated in a course of physical therapy with some overall improvement noted. Imaging studies revealed no significant pathology, and electrodiagnostic testing was negative for radiculopathy. I disagree with the previous reviewers comments regarding valid heart rate on FCE. The records do reflect a physiological response with increase in heart rate on testing; however, testing was terminated secondary to pain rather than deconditioning. It also is noted that the employee scored 50 or more on both Beck Depression and Beck Anxiety Inventories. These elevated scores are indicative of symptom magnification. It appears the employee has sustained a soft tissue myofascial strain-type injury and work hardening

is not supported as medically necessary.

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

ODG

<p>Work conditioning, work hardening</p>	<p>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.</p> <p>Criteria for admission to a Work Hardening (WH) Program:</p> <p>(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(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;</p>
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(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.

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.