CLAIMS EVAL

Utilization Review and Peer Review Services

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 3-31-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Multidisciplinary work hardening 5 x week x 2 weeks (8 hours daily)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
American Board of Physical Medicine and Rehabilitation

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

☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- DC., progress notes and chiropractic therapy on 10-12-09, 10-13-09, 10-15-09. Chiropractic therapy was provided in the form of muscle e-stim, ultrasound, and intersegmental traction at the lumbar spine.

- 10-16-09 DC., DWC-73.
- 11-3-09 MRI of the lumbar spine.
- 11-3-09 MRI of the cervical spine.
- 1-28-10 DC., performed a Doctor Selected by Treating Doctor Evaluation.
- 2-19-10 Functional Capacity Evaluation.
- 2-19-10 MS, LPC., performed a psychological assessment.
- Undated - work hardening treatment plan provided by, PT, MPT, MD., PhD, and, MS, LPC.
- 3-3-10, DO., Utilization Review.
- 3-4-10 B.PT, MPT., letter of clarification.
- 3-11-10, MD., Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

Progress note provided by, DC., on 10-12-09 notes the claimant is doing better. Chiropractic therapy was provided in the form of muscle e-stim, ultrasound, and intersegmental traction at the lumbar spine.

Follow up chiropractic therapy provided with Dr. on 10-13-09, 10-15-09. The claimant was returned to work with restrictions on 10-16-09.

MRI of the lumbar spine dated 11-3-09 shows at L3-L4, a broad based posterior 2 mm disc protrusion containing a peripheral annular tear in the left foraminal zone. At L4-L5, there is a broad based posterior 2 mm disc protrusion without foraminal stenosis. There is mild facet hypertrophy bilaterally.

MRI of the cervical spine dated 11-3-09 notes no evidence of fracture, disc herniation, central canal or foraminal stenosis. Periligamentous edema involving the anterior longitudinal ligament that may be reflective of posttraumatic inflammation and reparative change in the proper clinical setting. Abnormal straightening of cervical lordosis in the neutral position. Dis desiccation at C2-C3 through C5-C6.

On 1-28-10, DC., performed a Doctor Selected by Treating Doctor Evaluation. The evaluator reported the claimant was not at MMI and estimated to be at MMI on 3-28-10. The evaluator recommended a trial of 10 sessions of work hardening and Functional Capacity Evaluation before consideration of return to work. If signs and symptoms continue, an EMG/NCS, epidural steroid injection and massage should be considered.

2-19-10 Functional Capacity Evaluation shows the claimant is functioning in the sedentary work level.

2-19-10, MS, LPC., performed a psychological assessment: The claimant indicates she is experiencing minimal symptoms of depression with a score of 7 on the BDI-II and minimal symptoms of anxiety with a score of 8 on the BAI. Although the scores on the BDI-II and BAI are minimal the patient endorsed mild to moderate symptoms on the Rehabilitation Symptom Pre- screen. The claimant endorsed at moderate perception of disability and mild symptoms of depression and anxiety. The PAIRS assesses the patients' tendency tea equate pain levels with functional impairment. High scores, >60, indicate a tendency for the patient to associate pain levels with impairment which could interfere in the rehabilitation process. The patient's responses do indicate beliefs that may interfere with the rehabilitation process. Results of this assessment indicate that the claimant is experiencing mild behavioral overlays that are secondary to her work

related injury. Her current behavioral overlays are a departure from her level of functioning prior to the work related injury. The patient has been unable to sustain full duty employment or her previous level of functioning since the time of the injury. Multidisciplinary intervention at this time would prevent continued dependence on the health care system. The patient has functional deficits and behavioral overlays that are a direct result of her work related injury. The assessment does not indicate any significant symptoms that would prohibit the patient from successfully participating in the work hardening program. There was no report of suicidal ideation or a primary substance abuse problem. It is recommended that the claimant participate in the WH program (eight hours per clay, five days per week) with a good predicted outcome. Strengths that the patient would bring to the WH program include the following; Stable work history, no premorbid psychiatric history, above average social support.

Undated - work hardening treatment plan provided by, PT, MPT, , MD., PhD, and, MS, LPC: the claimant was referred for work hardening program to improve strength, endurance and tolerance to work related positions and activities. The claimant is currently functioning in the sedentary work level. Based on the knowledge, the claimant will need to prepare for work in the medium Level. This PDL was obtained directly through employer contact. The claimant has good employment record and availability to return to work at pre-injury employer, cooperation from employer, excellent premorbid health with no limiting. The claimant's limitations at this time are functional strengths versus return to work PDL. The claimant will return to work within one week of discharge from the program. The claimant will function in the medium PDL for at least three consecutive days prior to discharge. Expectations for the claimant to return to work with no restrictions.

On 3-3-10, DO., performed a Utilization Review. It was his opinion that the patient works as a flight attendant and sustained her injuries on 8-28-09. She has undergone several chiropractic treatments that have provided limited improvement The Functional Capacity Evaluation revealed that the patient is functioning at a sedentary level and is required to be at a medium work level. The provider is requesting ten Work hardening sessions. However, there is no objective documentation with regards to the failure of aggressive conservative treatments that have been rendered to this patient that has failed to warrant the participation in this program. The therapy progress notes were not submitted for review to objectively document the clinical and functional response of the patient from the treatments received. At this point in time, the medical necessity of this request is not fully established.

3-4-10 B. PT, MPT., notes Dr. reported he attempted to contact the requesting provider on 3-2-10 at 4:50 pm ad left a "general voice mail message for the clinical side." The provider reported that their voicemail system does not indicate that any message was left by the peer review physician. Nonetheless, Dr. provides only on rationale as to why the requested services were denied. He states "there is no documentation with regards to the failure of aggressive conservative treatments that have been rendered to this patient that has failed..". There exists a most obvious explanation to this point. The RME physician reported clearly documents that these records were reviewed, which lead to his determination of all medical necessity for a work hardening program.

On 3-11-10 MD., performed a Utilization Review. The patient had a work-related injury on 8-28-09. Treatment to date includes medications, surgery, and chiropractic treatment. An appeal of the previously denied request for work hardening was made. The medical records reviewed now included progress notes of the chiropractic treatment sessions rendered. However, there was no documentation of a defined formal return to work goal agreed by the employer and employee which may be in the form of a documented specific job to return to with job demands that exceed abilities or a documented on-the-job training to warrant enrollment of the patient in the program. There is confirmation however that she is planning on returning to work if she can move from a sedentary PDL to a Medium PDL. Furthermore, the patient did not meet or document the following criteria set by Work Hardening Program guidelines. After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning; patient is not a candidate where surgery or other treatments would clearly be warranted to improve function. As such, the medical necessity of the requested treatment modality is not fully established.

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

Based upon the extensive documentation presently available for review, medical necessity for treatment in the form of a work hardening program would not appear to be reasonable per criteria set forth by Official Disability Guidelines. There is a documented history of a fall in the work place, and there are documented symptoms of cervical pain and lumbar pain. A lumbar MRI obtained on 11/3/09 revealed findings consistent with a disc protrusion at the L3-L4 and L4-L5 disc levels. A cervical MRI obtained on 11/3/09 revealed findings consistent with periligamentous edema in the anterior longitudinal ligament, as well as disc desiccation at multiple levels in the cervical spine. Previous treatment has included treatment in the form of supervised rehabilitation services, and it is documented that there is an ability to perform sedentary work activities per a recent functional capacity evaluation. At the present time, Official Disability Guidelines would not support a medical necessity for an attempt at a work hardening program. The above noted reference would not support a medical necessity for such an extensive program when there has been no functional progress made with previous attempts at rehabilitation services. As a result, per criteria set forth by the above noted reference, the prognosis for a successful outcome from such an extensive program is poor. Therefore, the request for work hardening program is not reasonable and necessary.

ODG-TWC, last update 3-26-10 Occupational Disorders of the Low Back – 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.

Other established guidelines: High quality prospective studies are lacking for Work Conditioning and Work Hardening, but there are consensus guidelines used by providers of these programs. The term "work hardening" was first introduced in the late 1970s (Matheson, 1985), with a description as a "work-oriented treatment program"

with an outcome of improvement in productivity. An assessment is necessary, and activities include real or simulated work activities. (Lechner, 1994) The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on Practice. (AOTA, 1986) In 1988 the Commission for Accreditation of Rehabilitation Facilities (CARF) addressed standards, suggesting that the programs must be "highly structured and goal oriented." Services provided by a single practitioner were excluded from CARF accreditation for work hardening. (CARF, 1988) As CARF accreditation includes extensive administrative and organization standards, the Industrial Rehabilitation Advisory Committee of the American Physical Therapy Association (APTA) developed the Guidelines for Programs in Industrial Rehabilitation. (Helm-Williams, 1993) This was primarily to offer more flexibility. Types of programs in these guidelines are outlined below:

Single-Discipline Exercise Approaches: Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of nonoperative therapy between acute PT and interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT guidelines, which appear below the ODG WH criteria.

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 ODG 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): 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.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**