



Notice of Independent Review Decision-WCN
CLAIMS EVAL REVIEWER REPORT - WCN



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

DATE OF REVIEW: 8-26-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening 2 x week x 5 weeks lumbar -- 97545, 97546

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

Chiropractor

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

- 1-16-09 DO., office visit.
- MRI of the lumbar spine dated 2-3-09.
- EMG/NCS performed by DO., on 2-27-09.
- On 3-20-09, a lumbar myelogram and post CT scan.
- 4-6-09 lumbar epidural steroid injection.
- Office Consultation with MD. on 5-1-09.
- 8-13-09 Surgery performed by MD.
- Follow up with Dr. on 11-13-09.
- Office visit with unknown provider on 1-21-10.
- Physical therapy on 2-2-10, 2-4-10, 2-8-10, 2-10-10, 2-15-10, 2-16-10 and 2-17-10.
- 6-3-10 PhD, LPC., office visit.
- Behavioral progress note on 6-30-10.
- Functional Capacity Evaluation dated 6-29-10.
- 7-13-10 DO., performed a Utilization Review.
- 8-4-10 MD., performed a Utilization Review.

PATIENT CLINICAL HISTORY [SUMMARY]:

On 1-16-09, DO., evaluated the claimant. The claimant complained of low back pain and left lower extremity pain. Since his injury he has not returned to his place of employment. On exam, the claimant had muscle rigidity, complete spasm of the lumbar paraspinal muscles bilaterally. Achilles reflex on the left was 1+/5 and 2+/5 on the right. Patel reflex bilaterally was 2+/5. Heel-walk was negative bilaterally. Kemp's test was positive on the left and negative on the right. Hyperextension test was posture on the left. Pin-wheel testing was normal except at left S1 showing hypoesthesia. Trigger points were found at the left lumbar paraspinal musculature. The

claimant ambulates with a slow and antalgic gait. The evaluator recommended physical therapy. The claimant was given a prescription for Vicodin, Flexeril and Motrin 800 mg.

MRI of the lumbar spine dated 2-3-09 showed at L2-L3 a 2 mm disc bulge which mildly impinges upon the thecal sac. At L3-L4, there is a 2 mm posterior disc protrusion which mildly impinges upon the thecal sac. At L4-L5 and L5-S1 there is a 4 mm posterior central disc protrusion which mildly impinges upon the thecal sac. There is moderately narrowing at the lateral recess at both segments.

EMG/NCS performed by DO., on 2-27-09 showed evidence consistent with a diagnosis of left L4 radiculopathy.

On 3-20-09, a lumbar myelogram and post CT scan showed a 3 mm disc bulge at L2-L3 which mildly impinges upon the thecal sac also mildly narrowing both the lateral recess. At L3-L4, a 2 mm posterior disc protrusion which mildly impinges upon the thecal sac also mildly narrowing both of the lateral recesses. At L4-L5 there is a 4 mm disc protrusion which mildly impinges upon the thecal sac and also moderately narrowing both to the lateral recess. At L5-S1, a 4mm left paracentral disc protrusion which mildly impinges upon the thecal sac. The disc protrusion also results in diminished opacification of the left S1 nerve root sheath through the lateral recess and severe left lateral recess as well.

On 4-6-09, the claimant underwent a lumbar epidural steroid injection.

Office Consultation with MD., on 5-1-09 notes the claimant has not had significant improvement. He continues to experience symptoms of giving out. In light of his failure to respond to injections, the evaluator reported no further injections would be beneficial. The claimant would like to consider surgery. The evaluator referred the claimant to Dr..

On 8-13-09, the claimant underwent lumbar microdiscectomy, laminectomy, foraminotomy and partial facetectomy at L5-S1 performed by MD.

Follow up with Dr. on 11-13-09 notes the claimant is status post surgery. He continues to relate improvement post op. He now describes a crampy pain in the left lower extremity with intermittent numbness and tingling in a non dermatomal distribution. On exam, motor strength is 5/5. Sensory exam showed no hypoesthetic pain. Range of motion of the lumbar spine was decreased secondary to muscle spasms. The evaluator recommended postop rehab.

Office visit with unknown provider on 1-21-10 notes the claimant reported some improvement in his lumbar pain. On exam, the claimant has moderate pain and discomfort at L3 - ilium bilaterally. There is moderate hypertonicity of the lumbar paraspinal muscles bilaterally found on palpation. Achilles reflex on the left was 1+/5, Achilles reflex on the right is 2+/5. Patella reflex is bilaterally 2+/5. Heel-walk test is negative bilaterally. Kemp's standing test was positive on the left and negative on the right. Pinwheel exam was normal except the left S1 which showed hypoesthesia. Diagnosis: Displacement of lumbar intervertebral disc without myelopathy, neuralgia, neuritis and radiculitis. Plan: the evaluator requested additional 6 visits of physical therapy ex 2. The claimant was continued with medications as prescribed. The claimant is to remain off work.

Physical therapy on 2-2-10, 2-4-10, 2-8-10, 2-10-10, 2-15-10, 2-16-10 and 2-17-10.

6-3-10 PhD, LPC., According to the patient, at the time of his injury, he was working when he was lifting a heavy trash can and injured his lower back. Mr. reports that he has pain levels at 7 out of 10, with 10 being very severe pain. He describes the pain in his low back as severe aching. He has

undergone conservative efforts, but continues to experience pain to his low back and much limited functioning. He reports numerous physical limitations, such as weakness and fatigue during physical activity. A Mental Status Exam was performed. Diagnosis: Axis I: 307.89 Pain Disorder Associated Psychological Factors and A General Medical Condition, Chronic, 309.28 Adjustment Disorder with Mixed Emotional Factors (Injury related). Axis II: V71.09 No Diagnosis. Axis III: Deferred to treating physician. Axis IV: Psychological or Environmental: mood swings, episodes of sadness, dysfunctional sleep patterns, unemployment, financial strain. Axis V: Current GAF 55, Prior to Injury 85. Recommendations: The claimant has indicated that he is experiencing significant emotional distress as a result of his pain, physical limitations, and financial strain caused by his work-related injury. He presently has limited coping skills for effective management of pain, depressed feelings, and anxiety, Based on available information and the onset of his symptoms, the current emotional disturbance is deemed to be injury related. Certainly, further skills could be gained in order to cope more effectively with psycho-physiological effects of the injury, manage her pain more effectively to prevent pain chronicity, and improve his overall quality of life. He is also a good candidate for a comprehensive conditioning physical/aerobic program such as the work hardening program. The WH program, in addition to individual support from the behavioral medicine staff, will enhance his chances for a positive long-term rehabilitation outcome. The claimant needs to understand the limitations of the medical field, the benefits of the conservative approach, and the patient's role in the rehab process. Treatment Plan: A cognitive-behavioral approach will be implemented. The patient will be trained in cognitive restructuring to help combat maladaptive thoughts and behaviors that are causing and maintaining mood disturbance caused by her work-related injury. To help improve stress management skills, the patient will be trained in self-regulation techniques, such as diaphragmatic breathing, guided imagery, and autogenic relaxation. These techniques will assist him not only in managing his stress, but also his pain. By providing the patient with additional tools to combat his pain, he will decrease/cease use of pain medications that he is currently taking. Ceasing use of these medications is essential when operating company equipment. In addition, the patient's fear of re-injury will be addressed along with return to work goals. Furthermore, sleep hygiene will be monitored and the patient will be educated on ways to improve the quality of his sleep.

Behavioral progress note on 6-30-10.

Functional Capacity Evaluation dated 6-29-10 shows the claimant had an increase in lifting capacity by 10 lbs to the Light Medium PDL from the Light PDL capacity. The evaluator recommended an additional 10 sessions of work hardening program.

On 7-13-10, DO., performed a Utilization Review. The appropriateness and the medical necessity of additional Work Hardening two times a week for five weeks to the Lumbar arc not established. The patient was last seen on 6/3/10 which showed that the patient has pain in his low back rated at 7/10 on VAS scores. There is associated weakness and fatigue. It was noted that the patient has had ten sessions of Work Hardening and showed increased range of motion and strength within the lumbar region as well as his Left lower extremity. Also, there is an increase in the lifting capacity from the Light Medium PDL to Light PDL category. However, the medical records have not provided the documentations regarding the patient's return to work plan as agreed by the patient and the employer. This is needed since one of the goals of this program is to place the patient back to work. In addition, the actual attendance records of this patient were not provided. Hence, this request is not substantiated at this time.

On 8-4-10, MD., performed a Utilization Review. It was his opinion that the request for additional work hardening 2 x wk x 5 wks lumbar 97545 97546 is not recommended as medically necessary. The patient has completed 10 sessions of work hardening to date; however, there is limited

documentation of improvement secondary to the program. The patient's range of motion and strength have only minimally improved. Current evidence based guidelines support up to 20 sessions of work hardening only with evidence of significant gains as documented by subjective and objective improvement in functional abilities. Given the lack of documented significant gains, the request for 10 additional work hardening sessions is non-certified. Case manager states she is authorized to discuss. The claimant made modest gains with WH to date. Further WH not indicated due to poor progress with prior sessions.

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

The patient has made minimal functional gains. There was limited supportive documentation. The patient's range of motion and strength has minimally improved. Current evidence based guidelines support up to 20 sessions of work hardening only with evidence of significant gains as documented by subjective and objective improvement in functional abilities. Therefore, the request for 10 additional work hardening sessions has not been established as medically necessary.

ODG-TWC, last update 8-17-10 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. (CARE, 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.

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.

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)