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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: Jan/27/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 Hours of Work Hardening Program

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:

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

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guideline 2010 Update Chapter Low Back: Work Hardening
Adverse Determinations, 12/11/09 and 12/29/09
Letter, Dr. : 12/23/09
Letter, Dr.: 01/13/10
Medical Evaluation, Dr.: 02/29/08
Designated Doctor Evaluation, Dr.: 08/29/08
Addendum, Dr : 10/23/08
Designated Doctor Evaluation, Dr.: 10/12/09
Functional Capacity Evaluation: 12/23/09 and 11/20/09
Psychiatric Evaluation: 11/04/09
Office Note, Dr. : 11/20/09

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a female waitress who slipped and fell on a wet floor on xx/xx/xx and landed on her buttocks. She treated for low back pain with bilateral lower extremity symptomatology. She worked sedentary light duty until 01/09/08 when she reported that even cleaning silverware aggravated her low back pain. She has remained off work since 01/09/08. Notation was made to a prior low back injury that was treated conservatively with complete recovery and no MRI or x-ray evaluation. Reference was made to preexisting L5-S1 spondylolisthesis. The claimant treated conservatively with physical therapy, medications, transcutaneous electrical stimulation, lumbar support and activity modification. Reference was made to radiographs on 01/02/08 that showed grade I spondylolisthesis at L5-S1 with large bilateral pars interarticularis lesions. Reference was also made to MRI evaluations from

01/21/08 and 02/05/08 that noted L5-S1 acute marrow edema, one centimeter of anterolisthesis of L5 on S1, two to three millimeter disc prolapse, significantly narrowed right foramen with less narrowing on the left and small disc prolapse at L4-5.

Electrodiagnostic studies completed on 02/28/08 indicated findings most consistent with moderate generalized peripheral neuropathy of uncertain etiology; increased insertional activity of the left L5 innervated tensor fasciae latae with reduced recruitment of the left L5 innervated tibialis anterior and peroneus longus; no evidence of acute or chronic denervation or reinnervation at that time; absent right tibial H wave response; and no clear evidence of distal or proximal entrapment neuropathy. A medical evaluation by Dr. on 02/29/08 indicated the claimant was not at maximum medical improvement with notation that electrodiagnostic studies and possible surgical consult were needed. The claimant was noted to be a smoker. Reference was made to an office visit on 05/22/08 with Dr. that indicated the claimant should consider lumbar reconstruction minimally invasive fusion at L5-S1. A designated doctor evaluation on 08/29/08 by Dr. noted ongoing use of Lyrica and Soma. Physical examination demonstrated satisfactory gait with ability to heel and toe walk; lumbar tenderness and limited motion; positive bilateral straight leg raises at 70 degrees; decreased sensation in a stocking type distribution; equal reflexes at 1; normal strength; and eight of eight positive symptom magnification. Dr. felt the claimant was at maximum medical improvement with a zero percent impairment and could return to work without restrictions. In an addendum on 10/23/08 Dr. felt the claimant was a poor surgical candidate.

A designated doctor evaluation was completed by Dr. on 10/12/09 with notation of ongoing low back pain with numbness in the bilateral toes and knees. Physical examination demonstrated a left sided limp; lumbar spasm with painful limited motion; intact sensation; reflexes equal at 1; inability to heel and toe walk with right sided strength at 4+/5 and left at 3+/5. A functional capacity evaluation conducted on 10/23/09 indicated the claimant tested at a medium physical demand level with notation she did not meet the job demands for lifting, carrying, pushing, pulling, reaching, overhead use and stairs. The functional capacity evaluation indicated the claimant met the sedentary demands of a secretary. Dr. reviewed the functional capacity evaluation and indicated the claimant was at maximum medical improvement with five percent impairment. Dr. felt the claimant could return to work without restrictions. The claimant underwent a psychiatric evaluation on 11/04/09 with notation that both injections and surgery were recommended but denied by insurance. The psychiatric evaluation indicated the claimant was an appropriate candidate for a multidisciplinary work hardening program that would address her mild depression, anxiety, work simulation and physical conditioning. Another functional capacity evaluation was conducted on 11/20/09 as an entrance to a work hardening program. The evaluation noted the claimant's work fell under heavy physical demand level and currently tested at a sedentary to light physical demand level. Dr. saw the claimant on 11/20/09 for referral to a work hardening program. Dr. indicated the functional capacity evaluation confirmed the claimant had functional deficit, had a position available as a waitress that exceeded her current capabilities and recommended ten sessions or eighty hours of a work hardening program.

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

On overview it is critical to note this patient has not been gainfully employed in over 2 years. The injury occurred over 2 years ago. The ODG Guidelines specifically outline a post injury cap indicating that the worker must be no more than 2 years past the date of injury, as workers who have not returned to work by 2 years post injury generally do not improve from intensive work hardening programs. The information in this case would not satisfy the ODG Guidelines regarding the program requested. The reviewer finds that medical necessity does

not exist for 80 Hours of Work Hardening Program.

Official Disability Guideline 2010 Update Chapter Low Back: Work Hardening

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

(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 Guideline

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-AMERICA 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

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] 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)