



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 7-1-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Outpatient work hardening program, eighty hours

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

Doctor in Chiropractic Medicine

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

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PATIENT CLINICAL HISTORY [SUMMARY]:

Per The Employer's First Report of Injury, the claimant sustained a work related injury on while employed at Facility as a correctional officer. On this date, the claimant reported she was reaching for a youth under his bed when he hit her in the face with his fist and a deck of cards, causing knee, shoulder, and neck pain.

Emergency Room visit. The claimant was treated and discharged.

CT of the head performed by MD., showed normal non-contrast CT of the head.

X-ray of the cervical spine performed by MD., showed there is mild disk space narrowing at C5-6 and to a lesser degree C6-7, no fracture, subluxation or dislocation is seen, prevertebral soft tissues are within limits, there is mild straightening of the curvature to the spine with cervical ribs present left greater than right.

MD., the claimant complains of knee pain and a headache since she was hit in the face. The claimant reported she was reaching for a youth under his bed when he hit her in the face with his fist and a deck of cards, causing knee, shoulder, and neck pain. Physical Examination: Musculoskeletal: Pain. Diagnosis: Chronic knee pain, pain to the right side of face from being punched. Plan: The claimant was given discharge instructions.

11-15-09 MD., the claimant complains of head and face pain. The claimant reports increased pain to her neck and throbbing through her head. The claimant also states she has chronic bilateral knee pain. Neurological Examination: Oriented, alert, non-focal exam. Impression: Assault, closed head injury, neck sprain-strain. Plan: The claimant was prescribed Ultram and Flexeril.

11-15-09 CT of the head performed by MD., showed no acute abnormality.

11-17-09 Unknown Provider, the evaluator noted that the claimant complains of knee, neck, and shoulder pain. The claimant describes the pain as intermittent and sharp. The claimant should begin physical therapy.

12-7-09 MD., the claimant complains of cervical and bilateral shoulder pain. The claimant has ongoing pain in her neck and shoulders. The level of pain is severe. Physical Examination: Neck: There is no jugular venous distention. Carotid pulses are normal without thrills or bruits. The trachea appears to be midline. The thyroid gland is normal in size. Neurological Examination: The claimant denied loss of consciousness, paralysis, hyperesthesia, anesthesia, motor weakness, change in taste, smell, hearing or sight, tremors, seizures, gait disturbances or headaches. Cranial nerves II-XII appear to be grossly intact. There is no dysarthria, dysphonia or aphasia. Diagnosis: Cervicalgia, bilateral shoulder pain. Plan: The claimant was prescribed gel and Vicodin. The claimant will start physical therapy.

Chiropractic Therapy from 12-14-09 through 6-8-10 (12 visits)

12-17-09 MRI of the cervical spine performed by MD., showed right central disc herniation at C4-5, circumferential disc bulge at C5-6, loss of the normal lordosis which might be related to claimant positioning and-or spasm.

12-17-09 MRI of the left knee performed by MD., showed unremarkable appearing MRI of the left knee.

12-17-09 MRI of the left shoulder performed by MD., showed rotator cuff arthropathy and tendinitis with possible partial tear in the proximal supraspinatus.

12-17-09 MRI of the right shoulder performed by MD., showed rotator cuff arthropathy and probable tendinitis, no other definite finding.

12-17-09 MRI of the right knee performed by MD., showed bony lesion in the posterior aspect of the femur, this is somewhat suggestive of a possible osteoid osteoma, a radionuclide bone scan and radiographic correlation recommended.

12-30-09 MD., the evaluator noted that the claimant's pain in her neck has radiated into the left upper arm. The evaluator recommends that the claimant consider a cervical epidural steroid injection.

1-4-10 Statement Accepted Facts: The carrier accepts that the compensable injury extends to and includes sprain-strain to the bilateral shoulders, knees, and the cervical spine sustained on 11-14-09. The carrier disputes that the compensable injury extends to and includes any and all other body parts and-or conditions. The carrier specifically

disputes that the compensable injury extends to and includes bilateral shoulder tendinitis and osteoid osteoma in the right knee because these are ordinary conditions of life to which the general public is exposed outside of employment. There is no causal connection between these conditions and the compensable work injury.

1-7-10, MD., the claimant complains of cervical and bilateral shoulder pain. The claimant states the neck pain radiates down into her shoulders, bilateral knee and left shoulder pain. Physical Examination: Musculoskeletal: Cervical: Decreased range of motion in all planes with discomfort, diffuse paraspinal muscular tenderness, left greater than right, with mild hypertonicity, Spurling's test produces discomfort down into the neck and shoulders. Neurological Examination: The claimant denied loss of consciousness, paralysis, hyperesthesia, anesthesia, motor weakness, change in taste, smell, hearing or sight, tremors, seizures, gait disturbances or headaches. Cranial nerves II-XII appear to be grossly intact. There is no dysarthria, dysphonia or aphasia. Diagnosis: Cervicalgia, bilateral shoulder pain. Plan: The claimant will take prescribed medication. Cervical epidural steroid injection was ordered. The claimant will follow up with Dr. concerning her left shoulder rotator cuff tear.

1-15-10 Statement Accepted Facts: The carrier disputes entitlement of medical and disability benefits arising from cervical disc herniations because this is an ordinary condition of life to which the general public is exposed outside of employment. There is no causal connection between disc herniations in the cervical spine and the compensable work related injury on 11-14-09.

1-18-10 MD., the claimant complains of constant neck pain with associated radiation to the shoulders and arms. The claimant describes her pain as deep, dull with an occasional sharp, stabbing component. Physical Examination: Neck: There is a decrease in the range of motion with increased pain to both flexion and extension with some paravertebral muscle tenderness throughout the paravertebral muscles of the cervical spine. Deep pressure over the right and left cervical facets produces some radiating discomfort into the shoulders mildly reproducing the claimant's pain complaints. Knees: Reveals mild tenderness around the peripatellar areas, especially around the medial and lateral aspects of the peripatellar areas. There is a full range of motion of the knees. Sensory and motor appear to be intact. Deep tendon reflexes are equal bilaterally. Strength is mildly decreased in the upper extremities secondary to discomfort especially in the right upper extremity. Assessment-Plan: Cervical pain, cervical radiculopathy, internal disc derangement of the cervical spine, the claimant continues to have constant pain radiating down her back. Cervical epidural steroid injection is recommended. The claimant will continue therapy.

1-21-10 MD., the claimant complains of cervical pain. Physical Examination: Cervical spine with no significant pain with flexion, however, the claimant experiences discomfort with extension of cervical spine. The claimant has muscle spasm bilateral cervical paraspinals and bilateral trapezii. Bilateral shoulders with no significant

restriction of motion. Strength is 5-5. Right knee range of motion left knee 0 to 120. Medial joint line pain. McMurray test is negative. Lachman is negative. The knee is stable with varus and valgus. Range of motion left knee 0 to 120. Stable Lachman. McMurray test is negative. Lachman is negative. Diagnosis: Status post assault, cervical spine sprain, cervical spine muscle spasm, bilateral shoulder muscle spasm, impingement left shoulder, bilateral knee sprain, cervical spine disk herniations. Plan: The evaluator recommends continuation of conservative treatment. The claimant will begin a bicycle program. The claimant is a candidate for steroid injection and was prescribed no steroidal anti-inflammatories and muscle relaxants.

2-3-10 MD., performed a Medical Record Review. It was his opinion the compensable injury is a direct trauma to the right side of the face with contusion, possible cervical sprain (resolved), and possible knee sprains. Yes. The claimant is suffering from pre-existing degenerative changes in her cervical spine. The X-rays taken of her cervical spine reveal degenerative changes at two levels. The reason for the claimant's continued problems and need for treatment is unclear. The knee complaints are unsupported by the objective diagnostic testing. The shoulder complaints are also unsupported by the diagnostic testing, which is essentially normal. The cervical spine complaints are unsupported by the diagnostic testing, which does not show a lesion that would be compatible with her complaints. As far as the facial complaints are concerned, the effects of a contusion to the face should have resolved by this time. At this juncture, the Official Disability Guidelines would not support any of the above-mentioned treatments. Chiropractic care outside of the acute phase is not endorsed. Work conditioning and work hardening would not be necessary. For injections, surgery; and durable medical equipment, these types of treatments are not supported by the objective evidence on the MRIs or the medical records. However, medications such as ibuprofen could be appropriate. In summary, based upon the lack of objective support for any diagnosis other than a contusion or sprain, this claimant has exceeded the ODG treatment guideline criteria. Based upon the plethora of complaints and the normality of the studies, it is questionable whether or not symptom magnification is at play in this particular case.

2-24-10 EMG-NCV performed by MD., showed evidence of moderate C5 and C6 radiculopathy on the right, there is no electro diagnostic evidence of any other brachial plexopathy or peripheral neuropathy.

3-9-10 MD., performed a Designated Doctor Evaluation. He certified that the claimant had reached MMI on 3-9-10 and awarded the claimant 5% whole person impairment.

3-18-10 Functional Capacity Evaluation shows that the claimant is functioning at a Sedentary PDL.

3-24-10 A.R.S. MD., the claimant complains of cervical pain, bilateral shoulder pain, and bilateral knee pain. Physical Examination: Upper Extremities: On examination of the

upper extremities, left shoulder range of motion limitation were seen on flexion, abduction, internal and external rotation, shoulder elevation and depression. Left shoulder exhibits a positive impingement sign and positive Apley's scratch test. Examination of the right shoulder range of motion limited on abduction, internal, external rotation and elevation. Impingement sign was also positive for right shoulder, however, negative Apley's scratch test. Lower Extremities: On examination of the lower extremities, bilateral knees were limited on flexion and extension. Crepitus was heard in both knees and there was tenderness to palpation in both knees. Cervical Spine: On examination of the cervical spine there was decreased lordotic curve seen and this claimant has spasms seen bilaterally in the neck and upper back inure predominant on the left. Trier point tenderness was elicited bilaterally in the trapezius and supraspinatus muscles more so in the left. Cervical range of motion was tested and found to be limited on extension, flexion, lateral bending bilaterally, and bilateral rotation. Motor strength assessment revealed bilateral weakness in the distribution of the cervical nerve roots. C5 and C6, sensory deficits were also seen in the distribution of C5 and C6 bilaterally as well, deep, tendon reflexes were tested and found to be intact bilaterally. Impression: Cervical radiculopathy, left shoulder rotator cuff tear, bilateral shoulder tendonitis and arthropathy, bilateral knee pain, myofascial pain and spasms. Plan: The claimant was prescribed Motrin.

4-5-10 Howard Bernstein, MD., DWC-73: The claimant was returned to work from 4-5-10 with restrictions.

4-21-10 A.R.S. Prasad, MD., the claimant complains of cervical pain, bilateral shoulder pain, and bilateral knee pain. Physical Examination: Physical Examination: Upper Extremities: On examination of the upper extremities, left shoulder range of motion limitation were seen on flexion, abduction, internal and external rotation, shoulder elevation and depression. Left shoulder exhibits a positive impingement sign and positive Apley's scratch test. Examination of the right shoulder range of motion limited on abduction, internal, external rotation and elevation. Impingement sign was also positive for right shoulder, however, negative Apley's scratch test. Lower Extremities: On examination of the lower extremities, bilateral knees were limited on flexion and extension. Crepitus was heard in both knees and there was tenderness to palpation in both knees. Cervical Spine: On examination of the cervical spine there was decreased lordotic curve seen and this claimant has spasms seen bilaterally in the neck and upper back inure predominant on the left. Trier point tenderness was elicited bilaterally in the trapezius and supraspinatus muscles more so in the left. Cervical range of motion was tested and found to be limited on extension, flexion, lateral bending bilaterally, and bilateral rotation. Motor strength assessment revealed bilateral weakness in the distribution of the cervical nerve roots. C5 and C6, sensory deficits were also seen in the distribution of C5 and C6 bilaterally as well, deep, tendon reflexes were tested and found to be intact bilaterally. Impression: Cervical radiculopathy, left shoulder rotator cuff tear, bilateral shoulder tendonitis and arthropathy, bilateral knee pain, myofascial pain and spasms. Plan: The claimant was prescribed Motrin.

5-4-10 Functional Capacity Evaluation shows that the claimant is functioning at a Light PDL.

On 6-8-10 MD., performed a Utilization Review. The evaluator reported the claimant injured multiple body areas while struggling with a youth on the date noted above. Right knee MRI was interpreted as consistent with possible osteoid osteoma, but no acute abnormalities were identified. Left knee MRI was unremarkable. Left shoulder MRI showed rotator cuff tendinitis with possible partial supraspinatus tear. Right shoulder MRI showed degenerative changes without evidence of rotator cuff tear. Head CT was normal. Cervical MRI showed a right central C4-5 disc herniation and C5-6 disc bulge, without evidence of neural foraminal narrowing. No surgery is documented relating to this injury. Treatment has included 10 sessions of chiropractic physical therapy and one cervical epidural steroid injection. Per adjuster, claimant was terminated from her job on 1-12-10. On 2-17-10 the provider note documented 5-4-10 functional capacity evaluation (FCE) determined claimant to be at a Light physical demand level (PDL), while her occupation requires a Very Heavy PDL. 5-13-10 psychological evaluation documented minimal depression with sleep disturbance. Her only symptom was noted to be numbness anti tingling. She demonstrated a severe level of fear and avoidance concerning work activities. Psychologist recommended a trial of work hardening. A letter of medical necessity from the treating provider dated 05/20/10 indicated that she is not a surgical candidate. The current request is for 10 Sessions of an outpatient work hardening program (80 hours). The current request fails to meet Official Disability Guidelines (Work Loss Data Institute. Web-based version.) criteria concerning work hardening. Claimant is not currently employed, and a specific defined return-to-work plan has not been documented. This request is not authorized.

On 6-15-10 MD., performed a Utilization Review. The evaluator reported that the records presented fail to establish the clinical rationale to warrant the transition of this claimant to a work hardening program. Deficits from a March FCE do not establish a current measure of the claimant's functional levels. The mental health evaluation from 5-13-10 fails to establish any psychosocial deficits that would warrant transition to an upper level return to work program with a behavioral component. 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. (ODG Treatment Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute & Chronic))."

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

Based on review of all submitted documentation and evidence based guidelines (ODG), medical necessity for work hardening has not been established. Specifically, the submitted documentation fails to satisfy all inclusion criteria per Web Based ODG Pain Chapter Regarding Work Hardening.

First, the reported psychometric data is insufficient evidence of psychological barriers to warrant work hardening. Per ODG for Low Back Regarding Work Hardening “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”. ODG Pain Chapter refers to the Low Back Chapter for more information and references.

Next, there was no evidence of “demonstrated capacities below an employer verified physical demands analysis (PDA)”, per Web Based ODG for Pain Regarding Work Hardening (criterion 4). Specifically, there was no documentation from the employer regarding RTW requirements.

Additionally, criterion (9) states that there should be a “*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”. There was no evidence of a “specific defined return-to-work goal or job plan has been established, communicated and documented”.

Last, there was no documented evidence that the claimant has a job to return to with the absence of modified duty. Per Web Based ODG for Low Back Regarding Work Hardening “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”. Per ODG for Pain Regarding Work Hardening “See especially the Low Back Chapter, for more information and references”. Therefore, the request for work hardening program is not reasonable or medically indicated.

ODG-TWC, last update 6-15-10 Occupational Disorders: Pain – Work hardening:

Recommended as an option, depending on the availability of quality programs.

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.

ODG-TWC, last update 6-17-10 Occupational Disorders: 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 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.

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 KNOWLEDGBASE
- 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)**