



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 2-15-10

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work hardening program on 8-5-09, 8-12-09, 8-14-09, 8-19-09, 8-20-09, 8-26-09, 8-27-09, 8-28-09, 9-3-09, 9-4-09, 9-9-09, 9-11-09, 9-17-09, 9-18-09, 9-21-09, 9-30-09, 10-1-09, 10-27-09.

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

Board Certified in Occupational Medicine and American Board of Preventive 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

- 5-11-09, MD., Emergency Department visit.
- 6-16-09 physical therapy initial evaluation.
- 7-8-09, MS, BCIA-C, LPC. Mental health evaluation.

- 7-8-09 Functional Capacity Evaluation.
- Work hardening on 8-3-09, 8-12-09, and 8-26-09.
- 9-3-09 Functional Capacity Evaluation.
- 9-22-09, DO., performed a Billing Retrospective Review.

10-30-09, MD.,

PATIENT CLINICAL HISTORY [SUMMARY]:

5-11-09, MD., The claimant was seen at the ER. The claimant reported left rib pain, left leg and lower back pain. Impression: contusion at the hip. Diagnosis: Contusion of the left hip and sprain of the lumbosacral spine. The claimant was provided Toradol IM. The claimant was given a prescription for Norco, Flexeril and Naproxen. X-rays of left hip and lumbar spine showed mild degenerative changes otherwise unremarkable exam. The claimant was treated and discharged.

5-20-09 MRI lumbar spine without contrast interpreted by MD., Impression: Mild lumbar spondylosis and facet arthropathy, No central spinal canal stenosis, neural foraminal compromise or vertebral compression fracture identified.

6-16-09 Physical Therapy initial evaluation.

7-8-09, MS, BCIA-C, LPC., Initial Behavioral assessment. The claimant had attempted to return to light duty without success. The evaluator recommended the claimant was contending with a complex mixture of a pain and anxiety symptoms and many functional problems related to the aforementioned work related injury. The evaluator reported the claimant reported being diagnosed and treated for bipolar disorder 10+ years ago, which has been stabilized and managed since that time without any episode. The claimant present medications include Norco 10/325, Soma 350 mg, Tylenol with codeine, Cymbalta, Trazadone, Remeron, Lithium, Adderall and Seroquel. Diagnosis: AXIS I: Adjustment disorder with anxiety, acute. AXIS II, Bipolar disorder, depressed in full remission. AXIS III: Injury to low back. AXIS IV: Primary support group, economic and occupational problems. AXIS V: GAF current 50, estimated pre-injury GAF 85+. Plan: The claimant was a good candidate for the work hardening program and his psychosocial problems might have been effectively addressed in group therapy services offered in that program. If active symptoms did not abate with group therapy, He might have been eventually a candidate for additional individual psychotherapy.

7-8-09 Functional Capacity Evaluation notes that based on the findings the claimant did not meet the required PDL of Heavy for safe work performance at Cantex. Remarks: The claimants pain rating increased as he attempted to lift weights heavier than 20 pounds during occasional and frequent lifts, for that reason and validity of the FCE the claimant could have benefited from a work hardening program.

On 7-8-09, the claimant underwent physical therapy evaluation. It was noted the claimant was not able to perform at a Heavy PDL. Therefore, it was recommended the claimant participate in a work hardening program.

Work hardening on 8-3-09, 8-5-09, 8-12-09, 8-14-09, 8-19-09, 8-20-09, 8-21-09, 8-26-09, 8-27-09, 8-28-09, 9-3-09, 9-4-09, 9-9-09, 9-11-09, 9-17-09, 9-18-09, 9-21-09, 9-30-09, 10-1-09, and 10-2-09.

9-3-09 FCE showed the claimant would benefit from a work hardening program. The claimant was recommended another 10 sessions with the Work Hardening Program to achieve further gains of decreased pain and reaching his job requirements of a Heavy PDL.

9-22-09, DO., performed a Billing Retrospective Review. It was his opinion that there was no indication from the available documentation/information of the medical necessity for the work hardening program that was done from 8-3-09 to 9-4-09. The initial psychological evaluation prior to the start of the work hardening program indicated that the claimant had a pre existing history of bipolar disorder along with mention that there were some depression/anxiety occurring.

10-27-09 Discharge summary: The claimant reports that he sustained a work related injury to his low back on 05/10/09 while performing his customary duties as a maintenance technician at Canter Inc, Mineral Wells, TX. Per report, the claimant had been employed with the company for over 7 years at the time of the work injury. He reports that he was standing on the edge of a steel cooling tank attempting to remove a gearbox that controls the speed of a conveyor belt carrying parts through the cooling tank. Mr. loosened all required screws then attempted to pull the gearbox out, but it was stuck. When he pulled harder, it popped out very quickly causing him to lose his balance and fall backwards and down to the ground about 3 feet below. As he was holding the gearbox close to his chest and trying not to drop it, he was quickly pulled forward bending at the waist. As he was bent forward, he felt an intense piercing pain in his back and a burning pain down both legs. He was unable to straighten up for several minutes. After the pain subsided, he straightened up and he worked the rest of his shift in pain thinking the pain would go away. The next morning the pain had not gone away, but was actually much worse. He went into work and reported the incident to his supervisor,. Mr. was sent to the emergency room, where x-rays were taken and he was given an injection for the pain. He was given a prescription and released back to work on light duty, if available. The next day he called in to Cantex's human resource department and was told there was no light duty available and he should stay home until an appointment could be made with the company doctor, Dr., DO. It was about a week later that he had his initial appointment with Dr., who ordered a MRI and prescribed a steroid patch to help with the inflammation. He was told to stay off work. After approximately 7-8 days off, Mr. requested to be released back to work light duty. Mr. Leggett was still having severe pain in with his back, and requested to change treating physicians to Dr.. He was sent back to light duty for about 3 weeks, but he experience an onset of severe distress and he was sent to Hospital for a brief stay and stabilization. He was there 7 days and then released unexpectedly, but was told that his company no longer wanted him to get treatment at the hospital. The claimant was referred for behavioral medicine evaluation due to noted distress as well as complaints stemming from injury. Dr. recommended a Work Hardening Program (WHP), The WHP

was approved and the claimant began the program on August 3, 2009. He was approved for 20 days and completed 16 on 10/01/09. The claimant states that he is stronger, can lift and carry items that he could not before the program, and is able to complete tasks that he was not able to complete in the past. As the claimant has withdrawn from WHP, we are releasing him back to his treating doctor for his medical management.

10-30-09 MD., Letter of reconsideration - the claimant sustained an on the job injury while working as a maintenance worker for Cantex Distribution in Mineral Wells, TX on 5/10/09. His required physical demand level for work duties is classified as HEAVY. He was employed in the position for 7 years at the time of injury. There is a peer review on file from doctor, Dr. dated 9/8/09 which suggests the evaluator release him to go back to work with restrictions, which is what the evaluator did. The evaluator released Mr. Leggett to return to work with restrictions, but his employer would not accommodate him. It was at that time the evaluator decided to advance him into a comprehensive work hardening program to prepare him for full duty release. He underwent all necessary preprogram evaluations, including psychological work up and functional capacity evaluation. He met all ODG criteria for this type of program and was initiated on 8/3/09. The claimant resides in rural Mineral Wells, TX about 90 miles from Injury 1 in Wichita Falls and was unable to stay in local lodging for the duration of the program. Access to comprehensive program of this nature in small rural towns poses a challenge for many injured workers. Subsequently, his program was very reasonably modified in order for him to attend. He completed 15 days of work hardening making notable physical progress. All pain medications were discontinued and the evaluator released him to return to work regular duty without restrictions on 10/23/09. The paper peer review from Dr. on 9/8/09 states "No further physical therapy, work hardening/conditioning, or pain management programs are indicated". The evaluator will note that following her report of 9/8/09, Mr. Leggett only received 8 additional visits of work hardening until discharge. Dr.'s paper peer review suggests that Mr. Leggett's main problem is a long standing preexisting psychological condition. The evaluator disagreed with her assertion. Although this gentleman had a mental health history, the evaluator will note that he was stable and working for 7 years at Cantex Distribution in his maintenance position until the injury. It is clear from the records that his back pain and functional limitations brought about some adjustment problems, depression and anxiety symptoms. The evaluator felt that the work hardening program that the claimant participated in was very medically necessary. The claimant met all accepted ODG criteria for participation in the program at Injury 1 Treatment Center.

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

Based on the medical records provided, it is my opinion that he did meet the ODG criteria for the initial 10 visits of Work Hardening, from 8-5-09 through 9-4-09. ODG states that criteria for admission include appropriate screening, inability to perform his job demands, a Functional Capacity Evaluation, no further indication for surgical intervention and a treatment program. However, there was not good data indicating

significant improvements from the first 10 session; thus, I do not believe that last 8 sessions from 9-9-09 through 10-27-09 were reasonable or necessary.

ODG-TWC, last update 1-30-10 Pain – Work Hardening: Recommended as an option, depending on the availability of quality programs. [NOTE: See specific body part chapters for detailed information on Work conditioning & work hardening.] See especially the Low Back Chapter, for more information and references. The Low Back WH & WC Criteria are copied 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)