



IRO# 5356
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Notice of Independent Review Decision

DATE OF REVIEW: 04/20/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Work Hardening 5 x Wk x 2wks

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

This case was reviewed by a Texas licensed DO, DC, specializing in Plastic Surgery, General Surgery, Chiropractic. The physician advisor has the following additional qualifications, if applicable:

REVIEW OUTCOME:

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

Upheld

Health Care Service(s) in Dispute	CPT Codes	Date of Service(s)	Outcome of Independent Review
Additional Work Hardening 5x Wk x 2wks	97545	-	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

No	Document Type	Provider or Sender	Page Count	Service Start Date	Service End Date
1	IRO Request		17		
2	Diagnostic Test		2	03/23/2009	03/23/2009
3	Office Visit Report	San Antonio west	13	03/23/2009	06/18/2009
4	PT Notes	San Antonio west	1	04/14/2009	04/14/2009
5	Archive		2	07/20/2009	07/20/2009
6	Designated Doctor Report	DO	5	08/25/2009	08/25/2009
7	Psych Evaluation		5	12/08/2009	12/08/2009
8	FCE Report	Rehab	16	12/08/2009	12/21/2009
9	Office Visit Report	Rehab	37	12/09/2009	12/23/2009

10	Initial Request	Rehab	6	01/14/2010	01/14/2010
11	Appeal Denial Letter	Rehab	5	02/09/2010	02/09/2010
12	Initial Denial Letter		7	01/22/2010	02/23/2010
13	Office Visit Report	MD	16	07/25/2009	03/05/2010
14	IRO Record Receipt	TDI-DWC	5	03/31/2010	03/31/2010
15	IRO Request	Rehab	5	03/15/2010	04/01/2010

PATIENT CLINICAL HISTORY [SUMMARY]:

This is female who was helping transfer a 275 pound patient onto a bed with the help of associates. The patient resisted the transfer, was going to slip onto the floor, and the claimant held her weight, preventing the patient from resisting. In that incident, she felt a pull or a stretch to her lower back which worsened over the remainder of the day and later that evening. Her initial medical care was with Medical Centers. A Lumbar spine MRI scan was performed on May 1, 2009, which revealed no visible neural impingement; exceedingly small central disc protrusions at L4/L5 and L5/S1. She was prescribed a TENS unit and a lumbar support belt, as well as Biofreeze. An electrodiagnostic study of the lower extremities was also ordered. Her working diagnosis at that point included lumbar facet syndrome, lumbar strain/sprain, and right sacroiliitis.

Workers Compensation Services submits a 01-20-10 notice of denial for the request of additional work hardening sessions at 5 times week for 2 weeks to DC. This is per physician advisor M.D. (internal medicine). states that the clinical information submitted by the chiropractic provider fails to establish medical necessity for the request. Patient is as already completed 10 sessions of a work hardening program with mild improvement. Treatment is not supported for 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by objective gains in measurable improvement in functional abilities. Further information from peer to peer contact is required for certification determination.

Workers Compensation Services submits a denial per physician advisor DC for the initial request for work hardening program dated 02-23-10 to DC. states her rationale for denial of treatment is "the proposed treatment plan is not consistent with our clinical review criteria". We are unable to recommend the proposed treatment plan. There's an evaluation submitted from Healthcare Systems dated 12-08-09 in which they are referring the patient to MA, LPC for psychological evaluation to demonstrate day progress of a work hardening program. notes that prior treatment to date includes MRI and plain film radiographs, and treatment includes physical therapy, chiropractic care, topical analgesics, and heat/ice. Her medications include Flexeril 5 mg one by mouth, Naprosyn 500 mg 2 q.d., and Darvocet-N 100 2-3 p.o. q.d. The patient reports her pain scale without medications is VAS 7/10 and the pain is present 100% of the time. This patient has not effectively learned to cope with, and tolerate her pain. states that in her opinion, this patient would be a good candidate to enroll in a 20 session work hardening program. She is evaluated by M.D. on 08-08-09 Healthcare systems, and his findings confirm right sacroiliitis, lumbar facet syndrome, and lumbar spine strain sprain. She was recommended physical therapy 2 times a week followed by facet and right SI joint injections. Darvocet-N 100, and Naprosyn 500 mg, was prescribed at that point. She is evaluated by on 09-02-09 and essentially the same treatment plan is prescribed. notes the patient's care is at a standstill per his office visit note of 09-25-09. He states physical therapy will not be approved by carrier and by ODG guidelines, facet injections are not permissible until such time that lower levels of care have been addressed. submits his note of 10-30-09 and states the physical therapy sessions are pending approval, and that the patient is reporting that Darvocet is ineffective. He is now prescribing her Naprosyn 500 mg one twice a day and Flexeril 5 mg one to two as needed for pain. His note of 11-13-09 states she is no longer working. She still reports a dull stiff constant achy low back pain with intermittent sharp or radiating pain into her right lower extremity. Her pain is exacerbated on excessive sitting or standing. He is now prescribing her Biofreeze 3 tubes, a lumbar support belt, and a TENS unit. He is now prescribing her Ultram 50 mg one to two everyday, Naprosyn 500 mg one twice a day and Flexeril 5 mg one to two everyday. 12-11-09 office visit note reports that she is in her third session of the work hardening program. Her pain off medications is VAS 7/10 and with medications 5/10. He is maintaining her on the same oral medications at this time. His note of 01-08-10 states that she has completed 10 sessions of the work hardening program. She states her pain is 6-7/10 off medications, 4-5/10 on oral medications. Apparently the designated doctor D.O. has submitted his report, and apparently disputes his findings. Same oral medications are prescribed at this time and is requesting an additional 10 sessions of a work hardening program to improve the patient's range of motion and strength. She will have a BRC meeting within the next month, and at that point, facet injections will be requested. states on 02-12-10 that has placed her at MMI with a 0% impairment rating. states in his opinion

would benefit from a chronic pain management program and he states that she has improved dramatically during her participation in the 10 sessions the work hardening program. I feel further improvement is possible with the chronic pain management program. Same medications are prescribed at this time. Essentially her lumbar spine ranges of motion are the same as initially recorded, and her pain levels remain 7/10 off medications 5/10 with medication. submits examination findings dated 03-05-10 in which he states that the patient did in fact complete 10 sessions of the work hardening program and her PDL improved from sedentary to light which is still far below her work requirement which is medium heavy. Pain scale remains the same as those previous recorded as does her ranges of motion. He continues to request a chronic behavioral pain management program and same oral medications are prescribed. A 12-09-09 office visit note from DC states that the patient feels happy to be having care. submits an Interactive Group Therapy note dated 12-09-09, 12-15-09, and 12-21-09 via the work hardening program and her assessment includes that the patient participated actively in group therapy and needs little or no intervention to promote group interaction. Patient is actively progressing towards meeting her goals. Additional daily progress note for the work hardening program is submitted by S. Seidel, DC on 12-09-09, 12-10-09, 12-14-09, 12-15-09, 12-16-09, 12-17-09, 12-18-09, 12 21-09, 12-22-09, 12-23-09. There is a radiology report submitted from Medical Centers on 03-24-09 of the lumbar spine 4 views in which the radiologist opines under impressions: Mild degenerative changes without significant acute findings. An MRI scan report is submitted on 05-01-09 in which M.D. (radiologist) states under impressions no visible neural impingement on this MRI of the lumbar spine. #2 exceedingly small central disc protrusions at L4-S1. The neural foramina are widely patent. Facet joints are intact. The designated doctor is evaluation is now submitted for review by D.O. on 09-30-09 in which he notes this 5'0"/160lb female patient remains with pain to her low back 8-9/10. He reports that there was an FCE performed on 09-30-09 by DC which revealed a PDL of "sedentary" with the patient requiring "medium". He notes that the patient should return to work with restrictions which should last through 12-21-09. There are several office visit notes submitted for review from Concentra Medical Centers detailing this patient's initial interaction with the providers and there plan of care. There is a physical performance evaluation performed at Rehabilitation Center on 12-08-09 in which the chiropractic provider notes that in his opinion, she would benefit from a 4- week work hardening program. She has and anxiety level/depression of 45% with a perceived disability rating of 44%.

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

Is the request is for Additional Work Hardening x 10 sessions over 2 weeks reasonable and medically appropriate?

Based on the above documentation, there is scant evidence to support that this patient greatly benefited from her participation in the initial 80hrs of the work hardening program. Plain film radiographs, as well as, the MRI scan is essentially devoid of anatomic/surgical lesions that would require a full 160hr course of this program. Clearly, her persistent low back pain could be a result of her current body habitus as she is approximately 55lbs over her maximum ideal body weight. The requested additional 10 sessions of Work Hardening is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

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

- 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)**

TEXAS DEPARTMENT OF INSURANCE COMPLAINT PROCESS: The Texas Department of Insurance requires Independent Review Organizations to be licensed to perform Independent Review in Texas. To contact the Texas Department of Insurance regarding any complaint, you may call or write the Texas Department of Insurance. The telephone number is 1-800-578-4677 or in writing at: Texas Department of Insurance, PO Box 149104 Austin TX, 78714. In accordance with Rule 102.4(h), a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on 04/20/2010.

