MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 5/17/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 10 sessions of work conditioning.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is a board certified Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of 10 sessions of work conditioning.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient sustained a work related injury xx/xx/xx. According to records submitted by interviewers the patient developed pain in the neck, back, shoulders and right lower extremity due to an awkward position at a workstation that was not ergonomically sound. She tried to rearrange some furniture and material at her workstation, but she was subsequently required to move furniture to its original position.

She had conservative care including cervical epidural injections, Right SI injections, exercises and medications. She continued to work full time.

On 11/08/2008 the patient was seen at the office of Dr. by the physician assistant, for follow-up. The patient reported that she was working full-time, using a tens unit, bio freeze and Voltaren Gel. Mr. diagnosed right C6-C7 radiculopathy and SI joint dysfunction. The patient continued the tens unit, Mr. Senesi gave her some Xanax to try.

On 12/31/2008 Mr. noted decreased cervical range of motion and positive right straight leg raising. He recommended continuing the same treatment. On 3/05/2009 he diagnosed SI joint dysfunction and recommended another injection to the SI joint. On 5/12/2009 Mr. again recommended SI joint injection. On 8/12/2009 Mr. noted full neck range of motion. On 8/21/2009 Mr. recommended epidural steroid injections, noting that the neck pain had increased and was radiating into the upper extremities. On 9/02/2009 there was tenderness in the cervical paraspinous muscles and upper trapezius and spasms bilaterally. There was decreased range of motion of the lumbar spine. Mr. diagnosed chronic right leg pain, chronic neck pain with cervical radiculopathy, and SI joint dysfunction. He recommended EMG and nerve conduction studies and continuation of the medications.

On 6/15/2009 the patient was seen for RME at the xxxxxx in by Dr., an orthopedic surgeon. The patient reported trouble in the neck, right shoulder, right hand and leg, describing the insidious onset of discomfort due to an awkward position at a workstation that was not ergonomically sound. Examination revealed full range of motion of the cervical spine with minimal tenderness at the base of the neck. There was poor shoulder range of motion. She had tenderness in the area of the right SI joint. Dr. recommended myofascial release for the cervical spine and an aggressive strengthening exercise program for the lumbar spine, with a maximum of no more than one SI injection.

On a functional abilities evaluation 1/28/10, the score on the neck disability index was consistent with severe perceived disability, with a percentage rating of 52. The 42 percent score on the Oswestry back pain disability questionnaire was consistent with severe disability. Based upon the objective test findings, the patient met requirements to perform her job safely and efficiently, *with restrictions*. The examiner asserted the following:

- The patient is capable of performing their job duties (with restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment.
- The patient should continue with some form of continued active care … such as therapeutic exercise, active therapy, or some form of tertiary vocational therapy such as work hardening, or work conditioning which is designed, according to the patient's injury, to improve intolerance to work related positions, increase range of motion, decrease pain, increase strength, educate and help each patient to hopefully avoid any further injuries.

On 2/01/10 the patient was referred to xxxxxx for psychological evaluation and to determine the appropriateness of a work conditioning program. The examiner was, M.S., L.P.C. The patient described the onset of the pain, stating that she had tried to rearrange

some material and equipment at the workstation, but she was subsequently required to move furniture to its original position. The examiner diagnosed chronic pain disorder with significant period of disability, with no psychosocial barriers which may interfere with treatment. As psychosocial and psychological strengths the examiner listed motivation for treatment, average intellectual functioning and strong support systems. As a factor to consider differentiating secondary level of care from tertiary level of care, the examiner listed the time elapsed since injury and to the lack of responsiveness to previously attempted treatment, although the patient reported brief relief from previous treatments. Based on these findings the examiner recommended a work conditioning program for 20 sessions on a daily basis. Listed treatment goals included independent utilization of pain management skills and increased daily activity level. The short-term goals were to increase knowledge of chronic pain and accurately self-monitor and report pain.

A request for work hardening and work conditioning was submitted by Dr. 1/4/2010. The proposed treatments were non-authorized.

On 3/3/2010 Dr. submitted a request for an appeal, noting that the functional capacity evaluation January 28, 2010 documented physical defects which would "preclude her duties at her new position". The employer would allow time off from work to complete the proposed program.

On appeal, the proposed treatments were non-authorized on 3/19/2010.

One clinical note referred to an MRI of the cervical spine in June 2008 which was reported to show mild degenerative changes with no nerve root impingement.

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

According to the records reviewed above, the patient has continued to work full-time with some duty restrictions and limitations which were imposed on the basis of the functional abilities evaluation results. Based upon the recommendations at the RME examination in June 2009, the functional abilities evaluation in January 2010, and the psychological evaluation in February 2010, the patient can improve her functional status and progress to full-time work without restrictions. The proposed work hardening program falls within the ODG guidelines as a reasonable means to accomplish this goal.

- On the RME examination Dr. recommended myofascial release for the cervical spine and an aggressive strengthening exercise program for the lumbar spine, with a maximum of no more than one SI injection. He also recommended training in a home exercise program. All of these treatment measures can be accomplished as part of a 10-day work conditioning program.

- On the functional abilities evaluation 1/28/10, Based upon the objective test findings, the examiner stated that "the patient is capable of performing their job duties (with restrictions) until they demonstrate objective improvement and the ability to perform safely and efficiently at their place of employment". In order to attain the objective improvement the examiner recommended that the patient should continue with some form of active care “such as therapeutic exercise,

active therapy, or some form of tertiary vocational therapy such as work hardening, or work conditioning…". According to the ODG guidelines, a 10-day work conditioning program is a reasonable way to pursue these goals.

- On the psychological evaluation 02/01/2010, based upon the findings in the evaluation, the examiner recommended a work conditioning program, finding no psychosocial barriers which would interfere with the proposed treatment.

According to the ODG Treatment Guides pertaining to the Neck and Upper Back (Acute & Chronic) (updated 04/16/10), Work Conditioning and Work Hardening are addressed concurrently under the same topic heading.

Work conditioning, work hardening: Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. See the Low Back Chapter for more details and references. 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. **The request is for work conditioning rather than work hardening**

The key factor in any program is the objective measurement of improving functional performance with base line and follow-up testing. 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. **This was demonstrated on the functional abilities examination in January 2010.**

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. Work Conditioning should restore the injured worker's physical capacity and function. **The stated purpose of the requested treatment program is to "return to pre-injury activities".**
The ODG Treatment Guides include a list of Criteria for admission to a Work Hardening (WH) Program: Although the request has been made for Work Conditioning instead of Work Hardening, the following items have been addressed as documented in the submitted records:

(1) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.
(2) Screening Documentation: Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal,

cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.
(3) Job demands: A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).
(4) Functional capacity evaluations (FCEs): A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.
(5) Previous PT: There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.
(6) Rule out surgery: the patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).
(7) Healing: Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
(8) Other contraindications: There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.
(9) **RTW plan: A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.**
(10) Drug problems: There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.
(11) Program documentation: The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should documentation of the proposed benefit from the program (including functional, vocational, and psychological improvements) and the plans to undertake this improvement. The assessment should indicate that the program providers are familiar with the expectations of

the planned job, including skills necessary. Evidence of this may include site visitation, videotapes or functional job descriptions.
(12) Further mental health evaluation: Based on the initial screening, further evaluation by a mental health professional may be recommended. The results of this evaluation may suggest that treatment options other than these approaches may be required, and all screening evaluation information should be documented prior to further treatment planning.
(13) Supervision: Supervision is recommended under a physician, chiropractor, occupational therapist, or physical therapist with the appropriate education, training and experience. This clinician should provide on-site supervision of daily activities, and participate in the initial and final evaluations. They should design the treatment plan and be in charge of changes required. They are also in charge of direction of the staff.
(14) Trial: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective improvement in functional abilities. Outcomes should be presented that reflect the goals proposed upon entry, including those specifically addressing deficits identified in the screening procedure. A summary of the patient's physical and functional activities performed in the program should be included as an assessment of progress.
(15) Concurrently working: the patient who has been released to work with specific restrictions may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed 8 per day while in treatment.
(16) Conferences: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.
(17) Voc rehab: Vocational consultation should be available if this is indicated as a significant barrier. This would be required if the patient has no job to return to.
(18) Post-injury cap: The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two-years post injury generally do not improve from intensive work hardening programs. If the worker is greater than one-year post injury a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barrier to recovery (but these more complex programs may also be justified as early as 8-12 weeks, see Chronic pain programs).
(19) Program timelines: These approaches are highly variable in intensity, frequency and duration. APTA, AOTA and utilization guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs will fall within the following ranges: These approaches are necessarily intensive with highly variable treatment days ranging from 4-8 hours with treatment ranging from 3-5 visits per week. The entirety of this treatment should not exceed 20 full-day visits over 4 weeks, or no more than 160 hours (allowing for part-day sessions if required by part-time work, etc., over a longer number of weeks). A reassessment after 1-2 weeks should be made to determine whether completion of the chosen approach is appropriate, or whether treatment of greater intensity is required.
(20) Discharge documentation: At the time of discharge the referral source and other predetermined entities should be notified. This may include the employer and the insurer. There should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. Patient attendance and progress should be documented including the reason(s) for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential to benefit. There should also be documentation if the patient is unable to participate due to underlying medical conditions including substance dependence.

(21) Repetition: Upon completion of a rehabilitation program (e.g., work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.

ODG Work Conditioning (WC) Physical Therapy Guidelines
WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision (and would be contraindicated if there are already significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also Physical therapy for general PT guidelines. WC visits will typically be more intensive than regular PT visits, lasting 2 or 3 times as long. And, as with all physical therapy programs, Work Conditioning participation does not preclude concurrently being at work.
Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

The patient meets the requirement according to the ODG, therefore, the requested service is medically necessary.

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

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**