



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

DATE OF REVIEW: 12-14-11

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work Hardening Program x 80 hours/units CPT 97545, 97546

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

Psychologist

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

PATIENT CLINICAL HISTORY [SUMMARY]:

6-28-11 Initial Behavioral Medicine Consultation performed by MS, LPC/, MS, CRC, LPC., notes diagnosis:

Axis I: 307.89 Pain disorder associated with psychological factors and a general condition, chronic.

Axis II: V71.09, no diagnosis

Axis III: Injury to right ankle - See medical records & client report

Axis IV: Primary support group, economic, and occupational problems.

Axis V: GAF = 58 (current) Estimated pre-injury GAF= 85+.

Based on the information gathered through the initial interview with our offices and the patient's emotional presentation and verbal report, they would determine that the work accident, related pain and ensuing functional limitations have caused this patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. The patient appears to have been functioning independently prior to the work injury of xx/xx/xx.

9-27-11 Functional Capacity Evaluation shows the claimant is unable to perform his regular duties at this time. The claimant is capable of sedentary duty category safely.

10-25-11 MD., the claimant has full range of motion on flexion and extension of his right ankle. However, it does produce pain and discomfort on opposition. He continues to have hardware in his ankle. His neurological exam is unremarkable. Impression: Fracture dislocation with extruded body of the Talar status post surgery xx/xx/xx. Plan: Work hardening. He is placed on light duty with multiple restrictions. He was given no prescriptions.

MS, LPC, assessment for work hardening program. The evaluator reported he concurred with Dr. MD 's recommendation that the patient participate in a Work Hardening Program as the claimant has exhausted conservative treatment yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning, Thus, it is recommended that the claimant be approved for initial 10 day participation in the Work Hardening Program in order to further increase his physical and functional tolerances and to facilitate a safe and successful return to work.

Work hardening plan and goals of treatment. The patient sustained a work related injury. The patient has exhausted conservative courses of treatment and is unable to return to prior levels of functioning and work. An objective FCE and behavioral evaluation confirms necessity of this program. The patient requires, by medical necessity; a comprehensive occupational rehabilitation program for successful return to work and medical case closure. The patient has an agreed upon vocational goal. The patient has a targeted job to return to. The patient has met all accepted criteria for entrance into the comprehensive program. The patient meets all ODG guidelines for such an intensive rehabilitation program. The patient has a realistic opportunity to benefit from this program and should be admitted immediately.

claimant's report of work duties. His job title is a.

10-27-11 Psy, D., , Psy., Nicole Magnum, PhD., Preauthorization request for work hardening program. The claimant states that he sustained a work-related injury to his right ankle on xx/xx/xx while performing his customary duties as a . It is reported that a piece of sheetrock that weight approximately 1,000 pounds fell and crushed his right foot and ankle. He states that he had worked for the company 5 years prior to the injury. He reports that he went to the emergency room on xx/xx/xx and surgical repair was performed on his right ankle/foot. He has participated in physical therapy and individual psychotherapy. The claimant's treating physician is recommending that the patient be progressed to a work hardening program due to the patient's persistent functional deficits, which are impeding his ability to make a safe return to work on full duty. The patient is able to report reductions in pain, irritability, frustration, tension, anxiety, sleep disturbance, forgetfulness, and BDI-II depression score. His subjective depression has been maintained. Clearly, individual psychotherapy has exerted some positive impact on symptoms; however, the patient continues to demonstrate- some psychological

overlay. With the psychological overlay noted here, this patient will require a program with a group psychotherapeutic component, such as the one offered in the Work Hardening Program. The claimant should be authorized for the multidisciplinary return to work program. Multidisciplinary care would allow the patient the opportunity to manage these issues, address their fears with the patient community, enhance coping skills, and reframe their belief system related to their physical recovery. The patient has expressed a sincere desire to return to work on full duty. Certainly, a strong component of the program will focus on facilitating a return to work on full duty. The Functional Capacity Evaluation performed on 09/27/11 reveals the patient is functioning at a SEDENTARY PDL and the job requires a VERY HEAVY PDL. The claimant has shown modest improvement with outpatient physical therapy modalities and they are now recommending progression to a Work Hardening Program for progress to continue to be achieved. It is clear from the functional capacity evaluation that the current level of functioning due to injury interferes with the patient's ability to safely carry out specific tasks required at their workplace without risk of further injury and/or aggravation of the condition. Because the patient is not able to meet the requirements to safely return to work without re-injury/aggravation, the patient is likely to benefit from a Work Hardening program at this time. The patient is currently not working. The patient is likely to meet the required PDL to safely return to work with this program. The patient will be evaluated on a regular basis, and it is our expectation that they will return to pre-injury work status upon completion of the program. They expect they will regain full-duty status upon completion of the program.

11-2-11 UR performed by MD., notes the requested work hardening is denied. Although there is documentation that notes the patient is likely to meet his return to work PDL of very heavy, the exact plan of care for the next 2 or 4 weeks when current functional status is sedentary is not documented. Sedentary and very heavy have different criteria. Sedentary = up to 10 pounds occasionally; Very heavy = over 100 pounds occasionally. Per page 6 of the submitted documentation, they expect they will regain full-duty status upon completion of the program." Exact intervention or plan of care is not described or documented. This patient, after 17 months of being off work and after extensive post-op rehab is only functional at a sedentary level. Also, the patient's current poor function does not seem to be due to pain issues since the patient is not taking any medications. He spoke with Dr. Gabriel at 11:53am CST on 11-2-11 and the case was discussed. Dr. told me that the patient does not have a job to return to but his employer may take him back if he can return without restrictions. Dr. told me that he cannot guarantee that the patient would be able to reach a very heavy PDL (which is contrary to the assurances provided in the documents submitted to preauthorization). The patient does not have a job to return to which does not meet part of the criteria for participating in a work hardening program. See criteria #9.

11-14-11 Reconsideration request provided by, PsyD and PhD., notes 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. He has to reach a very heavy PDL for him to be offered a position to return to work at. They are aware that a very heavy PDL might not be realistic for this gentleman. His vocational history is limited to. They will

offer him vocational counseling once a week so he can explore vocational options within a light to medium PDL which are realistic. The claimant has completed 12 of 12 sessions of physical therapy, surgery, and 4 of 4 Individual therapy sessions. He has exhausted low level care for his injury. Additional physical therapy was requested but denied. He has made progress in outpatient physical therapy as before he was using a cane and taking medication. He no longer uses a cane or medication. MEDICAL NECESSITY: §408.021 of the Texas Labor Code, on Entitlement to Medical Benefits, states that: "An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

- i. Cures or relieves the effects naturally resulting from the compensable injury; or
- ii. Promotes recovery; or
- iii. Enhances the ability of the employee to return to work or retain employment.

11-22-11 UR performed by PhD., notes the additional documentation provided in the appeals correspondence did not adequately address these deficiencies and did not impact the prior recommendation for non authorization. The reviewer discussed this case with Dr. at 4:20pm CST on 11/15/11. The patient's history and clinical presentation is also clearly consistent with inference of a chronic benign pain syndrome and a Chronic Pain Disorder is diagnosed. [Official Disability Guidelines. (2011). Pain; ACOEM. (2008). Chronic pain. Occupational Medicine Practice Guidelines, 2nd ed.; p. 112; Chronic Pain Syndrome, 338.4: WHO. (2007). ICD-9-CM], which is generally inappropriate for a work hardening program; and clinically relevant pain behavior continues to be emitted. Dr. also reports that the patient does not have a job to return to at this time. Thus the request is inconsistent with ODG which states: "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". Thus, the PDL presented is academic since there is no such job available. Work hardening is job specific as opposed to generic conditioning exercise. An appeal letter on 11-14-11 states that "we are aware that a very heavy PDL might not be realistic for this gentleman." Thus the submitted documentation does not substantiate medical necessity of a work hardening program. These requirements for a work hardening program were not addressed and ODG criteria were not met. Therefore, it is recommended that the requested for a work hardening program x 10 days/80 hours was not reasonable and necessary. He contacted Dr. who stated he is authorized to discuss this case. The treatment goals, the claimant's vocational status and the claimant's current PDL were discussed. He recommended adverse determination.

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

THE PATIENT HAS COMPLETED DIAGNOSTICS, PHYSICAL THERAPY, HAD SURGERY IN 3/10, PSYCHOTHERAPY, AND HAS RECEIVED MEDICATIONS FOR THE INJURY. HE REPORTEDLY MADE SOME PROGRESS IN PSYCHOTHERAPY

AND "MODEST" PROGRESS IN PHYSICAL THERAPY. HE IS REPORTEDLY AT A SEDENTARY PHYSICAL DEMAND LEVEL WITH A REQUIRED LEVEL OF VERY HEAVY. HE REPORTEDLY NO LONGER HAS HIS JOB AND IS NOT CURRENTLY WORKING. PRIOR REQUESTS FOR WORK HARDENING WERE DENIED AS THE DOCUMENTATION NOTES THE PATIENT WILL NOT LIKELY ACHIEVE A VERY HEAVY DEMAND LEVEL. AS HE HAS NO JOB, THE ODG CRITERIA NOTE THAT A SPECIFIC VOCATIONAL PLAN SHOULD BE OUTLINED BUT THE PROVIDED PLAN IN THE DOCUMENTATION HAS VAGUE GOALS AND THERE IS NO SPECIFIC EVIDENCE OF A JOB OFFER AT A LOWER DEMAND LEVEL. BASED ON THE AVAILABLE INFORMATION, THE REQUEST FOR A WORK HARDENING PROGRAM X 80 HOURS/UNITS CPT 97545, 97546 CANNOT BE ESTABLISHED AS REASONABLE AND NECESSARY, PER EVIDENCE-BASED GUIDELINES.

ODG-TWC, last update 11-30-11 Occupational Disorders Pain - Work

hardening/conditioning: 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 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)