

# C-IRO Inc.

An Independent Review Organization

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## NOTICE OF INDEPENDENT REVIEW DECISION

**DATE OF REVIEW:** Jun/28/2011

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work Hardening 5 x a week x 2 weeks

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

M.D. Board Certified Orthopedic Surgeon

**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)

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

### PATIENT CLINICAL HISTORY SUMMARY

The claimant is a male who was the restrained passenger in a vehicle. The vehicle turned the corner too fast causing the vehicle to roll on xx/xx/xx. The claimant sustained injuries to his neck, thoracic spine, lumbar spine and left thumb. Reportedly the claimant was seen in the emergency room where a CT was done and medications prescribed. A cervical MRI on 04/27/10 reportedly revealed mild to moderate central canal stenosis C6-7 related to right paracentral disc protrusion; mild to moderate central canal stenosis C3-4 related to broad based disc protrusion with bilateral left greater than right foramina narrowing related to foramina disc osteophyte complex and left greater than right facet arthritis; and multi-level degenerative spondylosis elsewhere. A lumbar MRI on that date reportedly showed acute to subacute in age wedge compression fracture of T12; central disc protrusion with facet arthritis and osteophytic ridging at L5-S1 with mild bilateral foramina narrowing; central left paracentral disc protrusion at L4-5 which effaces the thecal sac anteriorly; and mild degenerative spondylosis elsewhere in lumbar spine. The claimant was noted to have treated with therapy. An initial behavioral medicine consultation on 05/24/10 noted that the claimant was taking Darvocet, Flexeril and Lyrica. A major depressive disorder was diagnosed and individual psychotherapy for a minimum of 6 weeks was advised.

Dr. performed a second opinion review of the cervical and lumbar MRIs from 04/27/10 and noted severe degenerative change cervical spine, spondylosis and associated disc protrusions at C3-4 and C6-7. These findings were most likely degenerative in nature with definite evidence of acute post traumatic change. There was also mild multilevel disc degeneration in the lumbar spine more at L4-5 and L5-S1. The small protrusions at L5-S1 were most likely degenerative in nature being broad based and small without significant neural compression. There was a prominent Schmorl's node at the superior endplate of T12 which was a chronic process. However there was linear T1 signal and bone marrow edema. Records indicated it may represent a superimposed acute or subacute fracture.

Dr. performed a required medical consultation on 09/30/10. It was noted that the claimant had been terminated x weeks post the injury. He was trying to do a home exercise program, but reported he was unable to be very physically active. The examination showed difficulty

getting out of clothing without assistance, difficulty bending over to take off shoes and socks and pull his pants off. He walked with a very stiff gait, had no difficulty with heel/toe walking and there was tenderness in the midline from T8-L1. Lumbar flexion was 80 degrees, but he then had to ladder himself back up to the upright position. He had pain with extension of 10 degrees or greater. Cervical flexion angle was to 50 degrees and extension to 50 degrees. He reported pressure on his eyes with extending the cervical spine 50 degrees. There was degenerative joint disease of the right knee and equal knee and ankle reflexes. Straight leg raise was negative. There were no significant neurological deficits. Dr. did not feel further therapy behind the initial 9 visits were necessary. He felt the psychological support was beneficial and needed to be continued. He did not recommend epidural steroid injections or durable medical equipment. He felt over the counter anti-inflammatories were appropriate, but Lyrica and Darvocet were not and should be tapered and discontinued. He felt the claimant was reaching MMI.

Dr. performed a post required medical evaluation on 02/03/11 at which time it was noted that the claimant was still treating with Dr. who was restarting therapy, which the claimant reported sometimes made his back pain worse. He had not returned to work or any meaningful activity. The claimant reported low back pain, tightness in the neck radiating into the arms with headaches and low back pain radiating around the groin bilaterally and a catching sensation when he walked. Dr. indicated that the claimant was at MMI as of that day and assigned a 15 percent whole person impairment rating. He concurred with active therapy, but felt that could be accomplished with a home exercise program. He felt the claimant could do sedentary type activities.

Dr. saw the claimant on 03/14/11 and noted no significant improvement with therapy. His pain was worse with prolonged sitting, standing, coughing or sneezing or Valsalva. His medications were Lisinopril, Hydrocodone, Lovastatin and Lyrica. Lumbar motion was decreased in forward flexion due to pain. He had 4/5 strength in the gastrocnemius muscle on the right and 1+ right ankle reflex. There was an antalgic gait, difficulty toe walking, less difficulty heel walking and no difficulty with tandem walk. Straight leg raise was positive bilaterally at 50 degrees. There was a hypoesthetic region L5 and S1 distributions on the right to pinprick and light touch. Lumbar spondylolisthesis L5-S1 grade 1; lumbar mechanical/discogenic pain syndrome; lumbar radiculitis; lumbar disc displacement and lumbago were diagnosed and an evaluation for epidural steroid therapy and lumbar spine x-rays with flexion/extension views were recommended.

A functional capacity evaluation on 04/01/11 noted the claimant's job to be within the heavy level of demand. The claimant had an 82 percent validity profile which suggested good effort and valid results. He was felt to be capable of sedentary-light level of demand for 8 hours/day. A trial of work hardening was indicated.

Dr. saw the claimant on 04/06/11 and stated his headache and left thumb pain were gone and his right shoulder pain improved, but he had neck, upper, mid and low back pain. He had significant difficulty moving, sitting from standing and standing from a chair. He had a slight limp, had decreased cervical motion due to pain and paracervical muscle tenderness and spasm. Flexion of the back was at 30 degrees and extension 5 degrees. Tramadol, Norco and Mobic were prescribed and therapy ordered. At the 05/04/11 followup it was noted that the medications were helping. Lumbar x-rays the day before reportedly showed no fractures, mild multilevel spondylosis and facet degeneration at L4-5 and L5-S1. He had a slight limp and slightly decreased neck motion. A work hardening program was recommended, but denied on 05/26/11 and 06/07/11 reviews.

#### **ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION**

The requested work hardening program five times a week for two weeks is medically necessary based on review of this medical record.

This is a gentleman who was injured in a rollover accident. He has undergone numerous diagnostic studies that show degenerative change of his back and he has had chronic back pain. He has been treated with multiple modalities to include physical therapy without good improvement and has recently had a functional capacity evaluation indicating that his job is a heavy duty job and he only can work at a sedentary duty position and he therefore needs work hardening.

Official Disability Guidelines for work hardening are reviewed which document the fact that patients should first have a functional capacity evaluation to determine the level of function. There should be previous physical therapy and no need for upcoming surgery. There should be a return to work plan and documentation of a drug issue and the patient should be released to a lighter duty job category while going to work hardening to try and increase their overall level of activity. This patient was capable of working in his regular job up until the time of his injury, and although he has been fired from that job, it would appear there are other jobs available and therefore, there would be a job category for him to return to at sometime in the future.

Therefore, in light of the fact that it was felt at the time of his functional capacity evaluation that his testing was valid, and the fact that he does not have a surgical lesion and has already had less than full improvement with lesser conservative care, then the requested work hardening for two weeks is medically necessary. The reviewer finds there is a medical necessity for Work Hardening 5 x a week x 2 weeks.

Official Disability Guidelines Treatment in Worker's Comp, 16th edition, 2011 Updates, Pain Chapter – Work Hardening

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-year 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 Guideline

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-AMERICA 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)