

CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: JULY 26, 2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

97545 Work Hardening x10 Sessions

97546 Addtl Work Hardening

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

This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years experience.

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

November 30, 2010: Mr. was examined by Dr. who recommended an MRI of the lumbar spine, left butt. He planned to treat Mr. for 6 sessions of spinal and joint stabilization and physical modalities to reduce muscle spasms and increase ROM and to reduce pain. He also planned to use muscle stimulation, ultra sound and massage, manual therapy and joint manipulation to the injured area.

December 2, 2010: Mr. was examined by Dr. who noted Mr. to have lower left back hip and butt discomfort. He treated Mr. with spinal stabilization and physical modalities.

December 6, 2010: Mr. was examined by Dr. who treated Mr. with spinal stabilization and physical modalities. He noted that Mr. could not perform all of his everyday activities without difficulty. Driving and bending was still slow to perform. ROM was restricted in all movement. Dt. still felt that Mr. needed and MRI of the lower back and hip and buttocks.

December 9, 2010: Mr. was examined by Dr. who requested an MRI of the lumbar and left hip and butt area.

December 15, 2010: MRI Left Hip (read by: , MD, PA) Impression: There are bilateral foci of marrow signal alteration believed to be small foci of red marrow. There is a minimal and likely physiological right hip joint effusion. There is a minimal and likely physiological left hip joint effusion. The prostate is diminutive in size and there is enlargement of the lumen of the prostatic urethra. MRI of the left hip and visualized pelvic region reveals no other pathology. **MRI Lumbar Spine with flexion and extension (read by Marc Berger, MD, PA) Impression:** At L2-3, there is a 4 mm central bulge of the disc with commensurate impression on dura and no impression on the origin of the nerve roots. The disc is dehydrated and mildly moderately decreased in height. At L3-4, there is a 3 mm central bulge of the disc with commensurate impression on Dura and no impression on the origin of the nerve roots. The disc is dehydrated and mildly decreased in height. At L4-5, there is a 3 mm central bulge of the disc with marginal impression on Dura and no impression on the origin of the nerve roots. The facets are mildly degenerative. The disc is mostly dehydrated. There is a small focus of HIZ indicative of a small left posterior annular tear. At L5-S1, there is no spondylolysis but there is a 5 mm anterior spondylolisthesis of L5 in relationship to S1 secondary to advanced degenerative facet disease and there is a 4 mm central bulge of the disc with no impression on Dura. There is a small focus of HIZ indicative of a small posterior annular tear. There is slight central stenosis and mild lateral recess stenosis. There is mild neuroforaminal stenosis. There is suggested borderline constriction of the left L5 nerve root. The disc is overtly dehydrated and has moderate decrease in height.

December 17, 2010: Mr. was examined by Dr. who sought a neurosurgeon for Mr.. He also planned to treat Mr. for spondylolesthesis post injury.

January 10, 2011: Mr. was examined by Dr., MD who sent him to Dr. for L4/L5 L5/S1 ESI and facet injections and physical therapy. He prescribed him Lyrica.

January 29, 2011: Mr. was examined by Dr., MD who sought authorization for L4-5 LESI under fluoroscopy and MAC anesthesia.

March 5, 2011: Mr. was examined by PA, who continued him on Ultram and waited for authorization for the requested injections.

April 5, 2011: Mr. was examined by Dr. D.C. who requested an FCE examination. Mr. was also examined by, PA who continued him on Ultram and waited for authorization for the requested injections.

April 6, 2011: FCE- Recommendations: It is recommended that Mr. participated in a work hardening program to improve his range of motion, flexibility, functional strength, physical endurance, positional tolerances and to provide the patient with education regarding body mechanics/ergonomics and pain management skills.

April 10, 2011: Request for reconsideration by Dr. MD for ESI.

May 24, 2011: Mr. was evaluated by Dr. PhD who recommended a work hardening program to help him rebuild the skills, strength and stamina to do his job.

May 26, 2011: Report of Medical Examination (by: Dr. MD) Conclusion: Sprain Lumbar Region- Dr. felt that Mr. did not reach MMI according to records provided and examination.

June 1, 2011: Mr. was examined by PA, who sought authorization for LESI at L4-5 at SCAR with fluoro and mac anesthesia.

June 1, 2011: M.D. performed an UR on the claimant. Rationale for Denial: The FCE has too many inconsistencies and inadequate evidence of exhausted available medical treatments.

June 6, 2011: A DWC form 69 was completed by Dr. MD who certified that Mr. did not reach MMI but should on or about 8/30/11.

June 7, 2011: Mr. was examined by Dr. who noted that after 6 TENS treatments and since Mr. has had reduction in his pain scale to a 5 after each treatment, Mr. was a good candidate for a rental of a TENS unit for his lower spine injuries. He

recommended him so start the work hardening program in the beginning of July 2011.

June 9, 2011: M.D. performed an UR on the claimant. Rationale for Denial: "It is abundantly clear that a full effort was not provided on the FCE." "Work Hardening program is not indicated when individuals have no job to return to work to."

June 20, 2011: Request for reconsideration by Dr for the rental of a TENS unit for Mr..

PATIENT CLINICAL HISTORY:

The claimant was injured when he slipped and fell on an icy roof.

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

Denial of work hardening is upheld because several of the ODG criteria are not met. The following ODG Criteria were not met: 1. There is no screening with a mental health provider regarding psycho social barriers to recovery. 2. Submitted clinicals do not specify the job demands which are the goal to return to. 3. Submitted FCE does not specify current functional level. 4. Submitted clinicals do not clarify whether further treatment options are open injections have been requested but there is no mention as to whether they were eventually authorized or pursued. There is also a question as to whether surgery has been ruled out. 5. There is a question as to a return to work plan. 6. Submitted documents do not indicate past/current medications and issues stemming from medication use. 7. 10 visits of work hardening have been requested, but the number of hours, over number of days/weeks is not specified.

Per the ODG:

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 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.

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
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)