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Notice of Independent Review Decision

DATE OF REVIEW: 04/25/11

IRO CASE NO.:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Item in dispute: Work Hardening Program / 10 Sessions
97545, 97546

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

Texas Board Certified Physical Medicine & Rehabilitation
Texas Board Certified Pain Management

REVIEW OUTCOME

Upon independent review, the reviewer finds that the previous adverse determination/adverse determination should be:
Denial Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY (SUMMARY):

The employee is a female who sustained an unknown injury on xx/xx/xx. The employee is status post surgery to the right wrist on 08/20/10.

A clinical note by Dr. dated 02/03/11 stated the employee reported intermittent right wrist pain rating 4 out of 10 that increased to 6 out of 10 with use of the right hand. The employee also reported constant tightness of the first and second finger. Current medications include ibuprofen. Physical examination revealed normal deep tendon reflex testing. Tinel's was negative on the right wrist. Phalen's was slightly mild on the right wrist. The employee's grip strength was noted to be 35% of the expected grip strength. Range of motion of the right wrist was normal with pain. The employee was assessed with right wrist sprain/strain, tingling of the first and second fingers, and left wrist sprain/strain. The employee was recommended for a Functional Capacity Evaluation (FCE) with possible work hardening program.

A functional assessment was performed on 02/17/11. The employee's occupation required a medium-heavy physical demand level. The employee was capable of performing at a light physical demand level. The employee was recommended for a work therapy program.

The employee was seen for initial psychological evaluation on 03/01/11. The employee complained of focal pain in the right wrist, index finger, and middle finger rating 3 to 5 out of 10. The employee stated she was currently functioning at 30% of her preinjury ability. The employee reported no history of substance abuse or suicidal attempts. The employee indicated that her financial situation was an additional stressor. The employee's thought process was fluid and coherent with no evidence of thought disorder. The employee denied suicidal or homicidal ideation. The BDI score was 29, indicating moderate depression. The BAI score was 27, indication moderate situational anxiety. The GAF score was 55. The employee was assessed with adjustment disorder with mixed anxiety and depressed mood and pain disorder associated with psychological factors and a general medical condition. The employee was felt to be a good candidate for a work hardening program, as well as concurrent individual psychological sessions.

The request for work hardening was denied by utilization review on 03/09/11. The FCE revealed the employee was capable of dynamic lifts up to 30 pounds, which was consistent with a medium physical demand level. The employee's injury was over x years old. There was no evidence the employee had reached a plateau from the physical therapy already provided. There was no evidence of attempts to return the employee to modified work duties or full duty work status prior to the current request. There was no written job verification from the employer for the employee to return to, nor was there a job description/job demand per the employer. The employee should be capable of normal work duties already; if not, then modified work duties with a gradual transition to full duty work status was advised.

The request for work hardening was denied by utilization review on 03/16/11. The employee had not made any changes after the plethora of treatment that has been performed. The employee still had normal range of motion, reported pain, reported strength deficits, no job to return to, financial difficulties due to this injury, and had been diagnosed with physical and psychological factors, depression, anxiety, and sleep disorder. The employee met multiple variables found to be negative predictors of efficacy of treatment.

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

The requested work hardening for 10 sessions would not be recommended as medically necessary. The clinical documentation provided for review does not meet current evidence-based guideline recommendations regarding a work hardening program. There is minimal documentation to indicate that the employee has reasonably exhausted lower levels of care to include formal physical therapy. It is unclear from the clinical documentation if the employee has plateaued with physical therapy. No defined return to work plan was provided for review that includes a return to work agreement with the employer. Additionally, the employee's psychological evaluation recommended

that the employee undergo individual psychotherapy which suggests psychological factors that may impact the employee's performance in a work hardening.

As the clinical documentation provided does not meet guideline recommendations for the request, medical necessity is not established.

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

Official Disability Guidelines, Online Version, Forearm Wrist & Hand Chapter

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 co-morbid 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.