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## Notice of Independent Review Decision

**DATE OF REVIEW:** 09/12/11

**IRO CASE #:**

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

Ten sessions of work hardening, five times a week for two weeks

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

Licensed by the Texas State Board of Chiropractic Examiners

### **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.

Ten sessions of work hardening, five times a week for two weeks - Upheld

The ODG Criteria were not provided by the carrier or the URA

### **PATIENT CLINICAL HISTORY**

An MRI of the lumbar spine was performed on 01/14/11 revealed borderline mild central stenosis with minimal narrowing of the bilateral lateral recesses at L3-L4 and L4-L5 secondary to a 1 to 2 mm. diffuse annular disc bulge and mild bilateral facet joint hypertrophy at each level. At L2-L3, there was a 1 to 2 mm. diffuse annular disc bulge and posterior annular tear noted just abutting the ventral thecal sac without central/lateral recess or neural foraminal narrowing. Dr. performed a Designated Doctor Evaluation on 04/13/11 and felt the patient had reached Maximum Medical Improvement (MMI) on 03/02/11 and assigned him a 0% whole person impairment rating. Dr. initially evaluated the patient on 06/08/11. Right Achilles' reflex was diminished when compared to the left. He had numbness and tingling primarily in the right leg. There was weakness of the right leg and specifically, the right ankle. There was hypoesthesia on the right at L5 and S1. Supine straight leg raising was positive on the right at 65 degrees. Dr. diagnosed the patient with lumbar disc derangement and lumbar radiculopathy with probably myelopathy. He recommended referral. Dr. evaluated the patient on 07/05/11 and felt he had not reached MMI, as he required ongoing treatment in the form of a pain management consultation. It was felt the patient's current pain was not caused by the previous work injury to the low back, as his current symptoms are clinically and objectively different. Mr. diagnosed the patient with adjustment disorder with mixed anxiety and depressed mood, pain disorder with both psychological factors and a general medical condition, and chronic pain. Mr. felt the patient was an appropriate candidate for work hardening. The patient underwent FCE and Dr. felt the patient could not safely return to his usual and customary duties as a xx. Overall, he performed at the light physical demand level. On 07/15/11, Dr. wrote a preauthorization request on 07/15/11 for 10 sessions of a work hardening program. On 07/20/11, Dr. provided an adverse determination letter regarding the 10 sessions of work hardening. Dr. wrote another preauthorization request on 08/04/11 for the 10 sessions of work hardening. On 08/10/11, Dr. also provided an adverse determination letter from the 10 sessions of work hardening.

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

According to the evidence based guidelines, ODG Chapter for the Low Back, the following is the criteria for admission to a work hardening 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 four 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 patient's current validated abilities.

(10) *Drug problems:* There should be documentation that the patient'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 one to two 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 eight 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 two 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 eight to twelve 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 four to eight hours with treatment ranging from three to five visits per week. The entirety of this treatment should not exceed 20 full day visits over four 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 one to two 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.

Upon completion there, we will also note a second source: "Work hardening should be work accumulation and not just therapeutic exercise, plus there should also be psychological support. Work hardening is an interdisciplinary, individualized job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively

graded conditioning exercises that are based on the individual's measured tolerances. Work conditioning and work hardening are not intended for sequential use. They may be considered in a subacute stage when it appears that excess therapy is not working and a biopsychosocial approach may be needed, but single disciplinary programs like work conditioning may be less likely to be effective than work hardening or interdisciplinary programs." *(Carr 2006 and Washington 2006)*. The need for work hardening is less clear for workers in sedentary or light demand work, since the 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. As with all intensive rehabilitation programs, measurable functional improvement should occur after initial use of the work hardening. It is not recommended that the patients go from work conditioning to work hardening or to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. *(Schonstein-Cochrane, 2008)*. Use of the FCE to evaluate return to work require validated tests; see the Fitness for Duty chapter.

It does not appear that this patient has made significant improvement based on notes that were provided for review throughout his treatment that would give any indication that the additional 10 sessions would provide any significant benefit. The patient has had a transitional light-duty program, which is the best opportunity for him to return to full employment and full duty status for what appears to be a sprain/strain of the lumbar spine for which treatment has been exceeded pursuant to the ODG.

The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on practice *(AOTA, 1986)* and in 1988, the Commission for Accreditation of Rehabilitation Facilities *(CARF)* addressed standards.

The ODG Fitness for Duty chapter preface states, "When considering whether a worker is fit for duty, an appreciation of the workplace in general and the specific tasks is crucial." The position needs a detailed job description from the employer. Ideally, this information should be corroborated by the worker. The physician's role includes: (1) providing a critical assessment of the available medical information as to completeness and validity, (2) identifying impairments that can "reasonably be anticipated" to affect performance of essential functions, (3) determining if impairments are permanent, and (4) identifying impairments that may result in a sudden or gradual adverse consequence (e.g., incapacitation

in a safety-sensitive job, communicable disease) or a "direct threat" (i.e., significant risk of substantial harm to the health or safety of self, co-workers, or the public that cannot be eliminated by reasonable accommodation)."

Based on the patient's notes, he has not made significant improvement based on documentation following 12 sessions of therapy, which is in excess of the ODG nor is there objective information or evidence to substantiate the need to exceed the ODG is noted based on progression to date. The 10 sessions do not appear to be reasonable or medically appropriate based on the patient's condition. In reviewing the documentation provided for review, I do not feel the 10 sessions of the work hardening program five times a week for two weeks is appropriate. Therefore, the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE
- 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

**X 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)**

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

*Carr 2006 and Washington 2006*