

AccuReview

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Notice of Independent Review Decision

DATE OF REVIEW: April 17, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Hours of Work Hardening (10 sessions, 8 hours per session)

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 of experience.

REVIEW OUTCOME:

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

Overturned (Disagree)

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:

06-10-11: Emergency Physician Record by MD with Hospital
06-22-11: MRI Lumbar Spine without Contrast, Interpreted by MD
06-23-11: Evaluation by MD

06-30-11: Emergency Physician Record: Addendum Sheet from Hospital
06-30-11: Physical Therapy Progress Notes from Hospital (6-30-11, 7-11-11, 7-12-11, 7-13-11, 7-14-11, 7-15-11, 7-18-11, 7-19-11, 7-20-11, 7-21-11)
07-21-11: Physical Therapy Progress Report to Physician from Hospital
08-01-11: EMG/NCV of the lower extremities interpreted by MD
08-30-11: Re-evaluation by MD
09-20-11: Functional Assessment Report by DC with Injury & Clinic, LLC.
10-27-11: Occupational Rehabilitation Work Hardening Program Preauthorization Request from Injury Clinics
11-10-11: Re-evaluation by MD
12-15-11: Re-evaluation by MD
01-20-12: UR performed by DC
02-21-12: Functional Assessment Report by DC with Injury & Clinic, LLC.
02-24-12: Work Hardening Evaluation by ABD, MA, LPC
03-06-12: UR performed by Paul Eggert, DC
03-22-12: UR performed by DC

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx when he was driving and getting in and out of his vehicle repeatedly. He felt a “crack” in his low back and then had an onset of severe low back pain radiating to the left lower extremity. He was initially seen in the Emergency Room of Hospital where x-rays were performed and he was diagnosed with low back pain with radiculopathy and lumbar spasms. He was prescribed Motrin 600 mg and Zanaflex 4 mg and referred to Dr. from Southwest I Clinic. Dr. ordered an MRI and then referred the claimant to Dr..

06-22-11: MRI Lumbar Spine without Contrast, Impression: 1. Mild diffuse bulging L4-5 producing partial effacement of both proximal L5 nerve root sleeves. 2. Moderate bilateral foraminal encroachment L4-5. 3. Far left lateral disk protrusion L3-4 producing effacement of fat planes adjacent to the left L3 dorsal root ganglion.

06-23-11: The claimant was evaluated by MD. The claimant presented with complaints of low back pain radiating to the left lower extremity, mostly to the left knee and anterior upper third of the left leg, associated to numbness and tingling, with a pain level of 8/10. On physical examination he had decreased range of motion of the lumbar spine with spasm; deep tendon reflexes hypoactive in the left knee and ankle; decreased sensation in the distribution of the L4 and L5 nerve roots in the left side; straight leg raising positive in the left at 40 degrees; no gross motor deficit. Diagnosis: Lumbosacral radiculopathy with protruded disc at L3-4 and L4-5 with thecal sac impingement. Dr. recommended physical therapy with: heat, massage, exercise and modalities, daily for two weeks; then 3 times a week for 1 week. He was also to remain off work.

07-21-11: A Physical Therapy Progress Report to Physician from Hospital indicated that the claimant had completed 10 sessions of PT and was progressing ward goals, dysfunction remained. It was recommended he continue 3 times per week for 4 weeks.

08-01-11: EMG/NCV of the lower extremities, summary of findings: 1. Normal latencies and conduction velocity studies in both peroneal and tibial nerves. 2. Normal and bilaterally similar H-Reflex latencies. 3. Normal EMG in all the muscles sampled in the lower extremities and the lumbosacral paraspinals without any evidence of consistent neuropathic or myopathic changes.

08-30-11: The claimant was re-evaluation by MD who reported his pain level to be a 5-7/10. It was also reported that the claimant underwent an ESI to the lumbar spine, which did not help him. The claimant did report that the physical therapy had provided some help. Dr. discussed with the claimant that the next step would be an L3-4, L4-5 left decompressive laminectomy/discectomy. A Work Capacity Evaluation was ordered and the claimant was to decide what he wanted to do regarding future treatment.

09-20-11: The claimant underwent a Functional Assessment Evaluation in which it was determined he was capable of handling Medium work demands. His occupation doing landscaping and lawn maintenance requires a Medium-Heavy PDL. , DC recommended a work hardening program.

11-10-11: The claimant was re-evaluated by MD who reported the claimant continued to have low back pain radiating to the left lower extremity all the way down to the left foot with a pain level of 6-8/10. He was still not able to return to work. Dr. reported that both the surgical authorization and requested work hardening program were denied.

12-15-11: The claimant was re-evaluated by MD. On physical examination the claimant was found to have decreased range of motion to the lumbar spine with spasm; deep tendon reflexes were decreased at the ankles; decreased sensation in the distribution of the L4-5 nerve root on the left side; no motor deficit; straight leg raising was positive at 40 degrees, left. Dr. continued to recommend the work hardening program as a form of conservative treatment, or surgical intervention would need to take place.

01-20-12: UR performed by DC. Reason for Denial: There was no evidence that the requirement of "documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapy" as well as "diagnostic interview with a mental health provider" was satisfied.

02-21-12: The claimant underwent a Functional Assessment. Based on testing, the ROM results were indicative of less than average. The examinee displayed fair overall flexibility, as indicated by the ROM and Sensory Motor Skills and Performance tests performed. The JAMAR grip strength test was indicative of fair grip strength in his right and left hand. Manual Muscle Testing revealed major muscle groups of the upper and

lower extremities were within functional limits. The examinee displayed some notable trunk weakness in his abdominal and erector spinae muscles. The examinee demonstrated a good awareness and practice of body mechanics and safe lifting techniques. The examinee displayed average overall cardiovascular conditioning. It was felt the examinee demonstrated a consistent effort during one or all of the tests. He participated with enthusiasm and was perceived as having put forth his maximum voluntary effort. It was found that the claimant was capable of handling Medium work demands. Dr. recommended a work hardening program.

02-24-12: The claimant had a Work Hardening Evaluation by ABD, MA, LPC. Current medications were listed as Hydrocodone 500 mg, every other day when the pain is "excruciating" and Omeprazole for acid reflux. The claimant's pain was described as subsiding in his left leg from his knee all the way down to his ankle and the left side of his lower back and into his buttock region on the same side. His pain was rated a 6-7/10. The score on the Pain Beliefs and Perception Inventory indicated that the claimant did not understand enough about his pain but that it was constantly with him. The claimant reported that the following changes occurred in his life due to his pain: stays at home most of the time, frequently changes positions to try and get his back comfortable, walks more slowly than usual, cannot do the jobs around the house he once did, must lie down to rest more often, gets dressed more slowly, tries not to bend or knee down, has difficulty putting on socks, avoids any heavy jobs around the house. The claimant also reported that he avoids answering the phone because he is afraid it will be a family member or an elderly neighbor asking him to help with their yards. Overall Assessment of Patient: Mr. does appear to have a realistic grasp of what he could expect from a work hardening program. He stated he believes it would give him a better idea of whether or not his pain is going to improve. He also expects that the program would help him have a better understanding of what his physical limitations are. His long term goal is to be able to return to his same position at work. Recommendations: 6 weeks of work hardening to address his physical and psychological responses to the injury. The components of the program were listed.

03-06-12: UR performed by DC. Reason for Denial: 1. In this case there is a report of a psych eval in which it is reported that a number of psych measures were made, but no data from these measures are reported. The only information regarding any psych data came from the requesting provider during peer call in which he indicated that the BDI was 10. This suggests relatively mild depression and thus does not support a full WH program. 2. There is no evidence that the requirement of a specific defined return-to-work goal or job plan has been established, communicated and documented has been satisfied. 3. EE is currently ½ of a PDL category from his pre-injury PDL. A full 80 hour RTW program cannot be supported to bring about RTW FD.

03-22-12: UR performed by DC. Reason for Denial: A recent functional assessment was submitted for review demonstrating the job demand levels and current physical demand level of the patient, as well as attitudes and expectations toward the proposed treatment program. However, there is no documentation of failed attempts to return to work. Furthermore, as mandated per referenced guidelines, there is no objective

evidence in the medical records of a trail of active PT with improvement followed by plateau, in the form of Physical Therapy reports and/or re-evaluations; and evaluations for any psychological or drug barriers that would prevent the patient from participation to a work hardening program. In fact, as per nurse's case summary, the patient has been reported to have "mild depression". Although goals were mentioned, the medical records submitted for review did not indicate specific short and long-term goals for the proposed treatment sessions in terms of timeframe and duration. As per guidelines, 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. Hence, the medical necessity of the requested service is not substantiated at this time.

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

Denial of 80 hrs of work hardening is overturned/disagreed with. ODG Pain Chapter Criteria for Work Hardening have been met: Submitted information documents the injury and subsequent workup and treatment. Claimant attended ODG Low Back Chapter's recommended 10 basic PT visits. FCE documents deconditioned state and mismatch between current abilities (Medium PDL) and job demands (Medium-Heavy). Claimant has a return to work plan to return to same type of work as job of injury with same employer. The mental health evaluation revealed mild depression and occasional Hydrocodone use but not to severity requiring next level of multidisciplinary care (Chronic Pain Management). Therefore, the request for 80 Hours of Work Hardening (10 sessions, 8 hours per session) is an appropriate level of rehabilitation and medically necessary.

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 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)**