

## IRO NOTICE OF DECISION – WC

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Notice of Independent Review Decision

### IRO REVIEWER REPORT - WC

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**Date notice sent to all parties:** 7-10-12

**IRO CASE #:**

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

80 hours of Work Hardening Program

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

Board Certified in Occupational Medicine  
Diplomate American Board of Preventive Medicine

**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 medical necessity exists for each of the health care services in dispute.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW:**

- 4-21-11 MD, MRI of the lumbar spine
- 5-3-11 MD, EMG/NCV of the bilateral lower extremities
- 5-5-11 MD, office visit
- 8-18-11 MD, operative procedure
- 10-24-11 MD, x-ray of the lumbar spine
- Follow up with MD, on 3-12-12
- Psychological visit on 4-3-12

- 4-19-12 MD, office visit
- Behavioral Medicine Consultation on 5-14-12
- 5-16-12 Functional Capacity Evaluation
- 5-24-12 DO, office visit
- 5-25-12 Work Hardening preauthorization request
- 5-30-12 UR non certification for the requested work hardening program
- 6-4-12 Work Hardening request
- 6-11-12 Reconsideration Appeal of Adverse Determination

**PATIENT CLINICAL HISTORY [SUMMARY]:**

4-21-11 MRI of the lumbar spine without contrast interpreted by MD, showed at L4-L5 a 3 to 4 mm broad based poster central to left Para central discal substance protrusion/herniation. Substance mildly indents the thecal sac. Associated is 2 to 3 mm of superior substance extrusion. At L5-S1 a 3 to 4 mm left Para central discal substance protrusion/herniation that mildly indents the thecal sac.

5-3-11 EMG/NCV of the bilateral lower extremities interpreted by MD, showed bilateral L5-S1 lumbar radiculopathy. No NCV evidence of generalized peripheral neuropathy, plexopathy, or peripheral entrapments.

5-5-11 MD, the claimant complains of low back pain that radiates into the left lower extremity with associated numbness and tingling in a non-dermatomal distribution. Exam shows lumbar range of motion was decreased in forward flexion secondary to pain. Impression: Lumbar disc displacement. Lumbar Radiculitis. Lumbago. Lumbar myofascial injury. Plan: Evaluation for epidural steroid therapy. Chronic Pain Management Program.

8-18-11 MD, preoperative diagnosis: Chronic low back pain. Lumbar radiculopathy. Lumbar disc disease. Postoperative diagnosis: Chronic low back pain. Lumbar radiculopathy. Lumbar disc disease. Procedure: Fluoroscopically guided lumbar L5-S1 epidural steroid injection. Lumbar epidurogram. Use of fluoroscopy for accurate needle localization of the epidural space. Permanent x-ray records of the lumbosacral spine.

10-24-11 X-ray of the lumbar spine interpreted by MD, showed normal vertebral alignment. Suspect some lower lumbar facet arthrosis from L4-S1. No disk bulge. No spondylosis.

Follow up with MD, on 3-12-12, the claimant complains of low back pain that he rates an 8/10. Exam shows unimproved lumbar range of motion with flexion/extension/lateral bend. Motor strength is 4/5. Decreased sensation in left leg. Impression: Lumbar IDD. Lumbar internal disc disruption. Low back pain. Lumbar Radiculitis. Lumbar facet syndrome. Plan: Proceed with lumbar discogram with post CT scan. Continue Zanaflex. Continue home stretching.

Psychological visit on 4-3-12.

4-19-12 MD, the claimant complains of low back pain that he rates a 4/10. He reports of right leg weakness and numbness. Exam shows lumbar range of motion is unimproved with flexion, extension, and lateral bend. Motor strength is a 4/5. Impression: Lumbar IDD. Lumbar internal disc disruption. Low back pain. Lumbar Radiculitis. Lumbar facet syndrome. Plan: Norco and Zanaflex. Proceed with a lumbar discogram with post CT scan at the levels L2-3, L3-4, and L5-S1. He is a good candidate for diagnostic provocative discography. Continue home based stretching therapy and walking.

Behavioral Medicine Consultation on 5-14-12.

5-16-12 FCE shows the claimant is functioning at a Light to Medium PDL.

5-24-12 DO, the claimant complains of low back pain. Hand written illegible notes. Diagnosis: Lumbar disc syndrome and lumbar radiculitis.

5-25-12 Work Hardening preauthorization request - his job level is Medium. He is currently working at a Light-Medium capacity. Because the patient is not able to meet the requirements to safely return to work without re-injury/aggravation, the patient is likely to benefit from a Work Hardening program at this time. He is currently not working. He is likely to meet the MEDIUM PDL, with this program. The patient will be evaluated on a regular basis, and it is their expectation that he will return to pre-injury work status upon completion of the program. He expected that claimant will regain full-duty status upon completion of the program.

5-30-12 UR non certification for the requested work hardening program. 1) The patient has been treated with PT, medications, and at least two ESIs, 2) There is a MRI on 4/21/11 that does not show fracture, neurocompression, tumor, etc., 3) The neurosurgeon (Belle) as well as a neurologist find no objective findings of radiculopathy, 4) Mention is made of an EMG.NCV that shows bilateral L5-S1 radiculopathy, yet this is inconsistent with the imaging report and physical findings, 5) The IME on 6/27/11 found 3/8 Waddell's tests positive, indicative of symptom magnification, 6) There is no job description, but a FCE indicates the patient is at a light medium PDL, with a medium PDL required to return to work, 7) It is not clear the patient has a job to return to at this time, 8) The BAI is 0 and the BDI is 7, virtually normal, 9) This would not appear to meet ODG, 2012.

6-4-12 Work Hardening request - the evaluator noted he spoke with an employee at Wilks Masonry on 5-16-12 who reported that the claimant can reapply and will be offered employment if they have openings at the time of his application.

6-11-12 Reconsideration Appeal of Adverse Determination: Clinical data submitted indicates the worker fell from scaffolding and landed on his low back

(distance to and characteristics of the ground where he landed have not been provided) following which one of the boards from the scaffold fell upon him. The worker was transported to the clinic on the day of injury. The worker received evaluation and management services, participated in conservative care/physical therapy and underwent MR-imaging noting the presence of degenerative changes at L4-5 and L5-S1. There was no spinal fracture noted. The worker is reported to have undergone electrodiagnostic testing with the demonstration of bilateral L5-S1 radiculopathy; however, the worker was not considered to be a surgical candidate (unclear how this determination was made). The worker has received three epidural steroid injections without apparent sustainable therapeutic benefit: record of 03/12/12 suggests no therapeutic benefit from the ESIs. The worker is reported to have demonstrated (functional capacity evaluation of 05/12/12) light-medium physical demand level capability with a job requirement of medium. The worker is reported to have made what has been termed modest improvement with physical therapy provided to date (may be a few as 12 sessions over the course of the year). The current medications are limited to Hydrocodone and Tizanidine. The worker is reported to be eligible to reapply for his position, but at this time he does not have a position waiting for him. On functional testing the worker is able to tolerate a pace of ambulation and incline (3.4 M.P.H. and 14%) with a limited increase in heart rate (105 bpm) that suggests a good retained aerobic capacity. The perceived pain levels range to no greater than 3/10 with activity (but the summary report states perceived pain levels range moderate to severe and are function limiting). The physician who was to oversee or perform the lumbar discogram (Dr. on 03/12/12) noted the worker exhibited no untoward psychosocial issues. Given the limited discrepancy between the required physical ability for return to work in his prior occupation and the documented/ demonstrated performance during the functional capacity evaluation and after taking the other contributing and confounding factors into consideration, it remains apparent that enrollment in a multidisciplinary work hardening program is not appropriate and is not supported by current clinical guidelines.

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

Based on the records provided, the claimant is not able to meet the requirements to safely return to work without re-injury/aggravation. He has been treated with medications, physical therapy and epidural steroid injection. He has undergone the appropriate pre-screening and was deemed to be a good candidate. Therefore, the request for 80 hours of Work Hardening Program is reasonable and medically necessary to return the claimant to his previous level of employment.

**PER ODG 2012 PAIN CHAPTER - WORK HARDENING/CONDITIONING:**

Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty RTW program (see [ODG Capabilities & Activity Modifications](#))

for Restricted Work), rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. See also Return to work, where the evidence presented for “real” work is far stronger than the evidence for “simulated” work. Also see Exercise, where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job. Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapy provider or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic back pain, when compared to usual care. However, there is no evidence of their efficacy for acute back pain. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. (Schonstein-Cochrane, 2003) See also Chronic pain programs (functional restoration programs), where there is strong evidence for selective use of programs offering comprehensive interdisciplinary/ multidisciplinary treatment, beyond just work hardening. Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 2003) Work Conditioning should restore the client’s physical capacity and function. Work Hardening should be work simulation 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 the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work conditioning may be less likely to be effective than work hardening or interdisciplinary programs. (CARE, 2006) (Washington, 2006) The need for work hardening is less clear for workers in sedentary or light demand work, since 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 rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-Cochrane, 2008) Use of Functional

Capacity Evaluations (FCEs) to evaluate return-to-work require validated tests. See the Fitness For Duty Chapter.

**Other established guidelines:** High quality prospective studies are lacking for Work Conditioning and Work Hardening, but there are consensus guidelines used by providers of these programs. The term “work hardening” was first introduced in the late 1970s (Matheson, 1985), with a description as a “work-oriented treatment program” with an outcome of improvement in productivity. An assessment is necessary, and activities include real or simulated work activities. (Lechner, 1994) The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on Practice. (AOTA, 1986) In 1988 the Commission for Accreditation of Rehabilitation Facilities (CARF) addressed standards, suggesting that the programs must be “highly structured and goal oriented.” Services provided by a single practitioner were excluded from CARF accreditation for work hardening. (CARF, 1988) As CARF accreditation includes extensive administrative and organization standards, the Industrial Rehabilitation Advisory Committee of the American Physical Therapy Association (APTA) developed the Guidelines for Programs in Industrial Rehabilitation. (Helm-Williams, 1993) This was primarily to offer more flexibility. Types of programs in these guidelines are outlined below:

**Single-Discipline Exercise Approaches:** Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of nonoperative therapy between acute PT and interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT guidelines, which appear below the ODG WH criteria.

**Interdisciplinary Work-Related Exercise Approaches Adding Psychological Support:** These approaches, called Work Hardening (WH) programs, feature exercise therapy combined with some elements of psychological support (education, cognitive behavioral therapy, fear avoidance, belief training, stress management, etc.) that deal with mild-to-moderate psychological overlay accompanying the subacute pain/disability, not severe enough to meet criteria for chronic pain management or functional restoration programs. (Hoffman, 2007) See also Chronic pain programs (functional restoration programs). There has been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition back to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to successful return to work. Types of issues that are commonly addressed include anger at employer, fear of injury, fear of return to work, and interpersonal issues with co-workers or supervisors. The ODG WH criteria are outlined below.

### **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.

## **IRO REVIEWER REPORT - WC**

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### **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)**