

IRO NOTICE OF DECISION TEMPLATE – WC



Notice of Independent Review Decision

6-18-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work hardening x 10 sessions/80 hours CPT 97545, 97546

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

American Osteopathic Board of Family Physicians

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:

- 2-28-12 Functional Capacity Evaluation.
- 2-28-12 MS., office visit.
- 3-19-12 MD., office visit.
- 3-20-12 DC., Impairment Rating.
- 5-7-12 Assessment for Work Hardening Program.
- 5-9-12 Work Hardening Program Pre-Authorization Request.
- 5-15-12: Request for authorization of Work Hardening x 80 hours.
- 5-22-12 Reconsideration Work Hardening Program Pre-Authorization Request.
- 5-30-12: Reconsideration for authorization of Work Hardening 10 sessions-80 hours.

PATIENT CLINICAL HISTORY [SUMMARY]:

2-28-12 Functional Capacity Evaluation shows the claimant is functioning at a Light PDL.

2-28-12 MS., the claimant presents for a Psychological Evaluation. Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition; chronic. Axis II: No diagnosis. Axis III: Injury to left orbit and cervical. See medical records. Axis IV: Primary support and occupational problems. Axis V: GAF Current: 60; estimated pre-injury: 85. Plan: The claimant should receive immediate authorization for participation in 4 weeks of individual psychotherapy while she is awaiting approval of an MRI of her thoracic spine with and without contrast and neurosurgical evaluation. Further, the evaluator will work to reduce disturbances in mood and resolve psychosocial stressors by providing the appropriate community resource referrals.

3-19-12 MD., the claimant complains of left eye pain and neck pain. The claimant was involved in a work-related injury in with a handle struck her in the left orbit. She had immediate left eye pain and she describes a loss of vision in that eye, described as blurriness. She also describes some pain in her head, seeing spots, and also some pain in her neck. She was evaluated Hosp, had a CT scan of her head that was normal. She was prescribed Norco and was released. She presents to follow-up because she was working today and developed some

headaches and neck pain. She has been to see the Neurosurgeons. An MRI of the thoracic spine dated 3-14 2012 reveals no abnormalities. Physical Examination: The claimant is normocephalic and traumatic. Her extra ocular eye movements are intact. Her cranial nerves II through XII are grossly intact. Her mental status exam as appropriate. Her cervical spine has full range of motion of flexion-extension and rotation. There are no myospasms or myositis. Her upper extremities have full range of motion and good strength. Her neurological exam is grossly intact. She has a normal gait and ambulates without difficulty. Impression: Left orbital contusion, headaches, cervical sprain-strain. Plan: She is medically cleared for the work hardening program. She would be an excellent candidate for the work hardening program. She received no written prescriptions. She will continue with her light duty work restrictions on her DWC 73. She will be seen back in office in one month. She will call if symptoms worsen.

3-20-12 DC., performed an Impairment Rating. He certified the claimant had not reached MMI and estimated 3 months as the date of MMI. The claimant did see a neurologist where a MRI with contrast was recommended. She has been recommended to begin a return to work, Work Hardening Program and has demonstrated progress in past therapies. The claimant can be expected to continue to improve.

5-7-12 Assessment for Work Hardening Program: On this date, the claimant was seen for evaluation regarding her participation in the work. The claimant has been denied individual psychotherapy sessions, completed 12 physical therapy session and the neurosurgeons determined that she is not a surgical candidate. Hardening program recommended by her treating doctor, MD.

5-9-12 Work Hardening Program Pre-Authorization Request-to be scheduled upon approval. He notes there is no indication that the claimant has undergone psychometric testing with validity measures to assess the validity of her significant subjective complains. The claimant has not undergone any individual psychotherapy or been placed on psychotropic medications. The claimant continues to work light duty at this time.

5-15-12 Jerome Schmidt, PhD., notes request for authorization of Work Hardening x 80 hours. It was determined that it does not meet medical necessity guidelines.

5-22-12 Reconsideration Work Hardening Program Pre-Authorization Request-to be scheduled upon approval.

5-30-12 PhD., Reconsideration for Authorization of Work Hardening 10 sessions- 80 hours. It was determined that it does not meet medical necessity guidelines. He noted that work hardening is job specific as opposed to generic conditioning exercises. The medical necessity was not submitted. The treatment goals, vocational PDL were discussed. He recommended adverse determination.

ODG 2012 PAIN CHAPTER: WORK HARDENING/CONDITIONING:

Recommended as an option, depending on the availability of quality programs. [NOTE: See specific body part chapters for detailed information on Work conditioning & work hardening.] See especially the Low Back Chapter, for more information and references. The Low Back WH & WC Criteria are copied 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 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.

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

The claimant has a deficit between the actual PDL and the job PDL. Non-operative therapy and treatment has been maximized and the psychological evaluation notes the deficits which need to be addressed.

Therefore, a trial of 5 sessions/40 hours of work hardening is medically reasonable and necessary.

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)**