



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 2-27-12

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Work hardening 80 hours right hand/wrist 97545 WH 97546 WH

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

American Osteopathic Board of Family Practice

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- Office visits with Dr. on 1-14-10, 1-20-10, 3-31-10.
- DWC-73 provided by MD., on 3-10-10, 4-28-10, 6-7-10.
- MD., office visits on 6-7-10, 8-4-10, 2-8-11, 2-18-11, 4-18-11, 5-16-11,
- 8-18-10 Surgery performed by Dr.
- 11-17-11 Behavioral Evaluation.
- 11-17-11 Functional Capacity Evaluation.
- 12-16-11 DC., office visit.
- 12-22-11 MD., performed a UR.
- 1-2-12 DC., Request for reconsideration.
- 1-10-12 MD., performed a UR.

PATIENT CLINICAL HISTORY [SUMMARY]:

Office visit with Dr. on 1-14-10 notes the diagnosis for deQuervain's tenosynovitis and trigger finger. He recommended occupational therapy 2 x 4.

DWC-73 provided by MD., on 3-10-10, 4-28-10, 6-7-10.

3-31-10 MD., the claimant states she was assembling an air conditioning at work and felt a pop in her wrist. She complains of right hand pain, injury, tingling, swelling,

triggering and warmth. The condition was interfering with her ADL's. she had prior x-rays. Treatment has included NSAID's, splinting, and injection. The injection on 2-10-10 showed temporary relief. Her medications include Vicodin. On exam, the claimant has tenderness with palpation along the first dorsal compartment with flexion and ulnar deviation. The claimant has mild swelling along the radial aspect of the wrist. Motor testing is 5/5. The claimant has positive Finkelstein's test. Distal neurovascular exam is intact. The claimant has full range of motion when she gets beyond the trigger point. She has a palpable tender nodule over the A1 pulley of the small and middle fingers when reproduction of triggering on examination. The evaluator recommended was provided an injection for the triggering fingers and for the deQuervain's tenosynovitis.

8-4-10 MD., reported that the most likely source of digital numbness based on his exam was ulnar at cubital. The evaluator recommended trigger release of the right long and small finger and first dorsal compartment release.

8-18-10 Surgery performed by Dr..

On 2-18-11 Dr. reported that the injection administered to right CT as a test of responsiveness of this area to treatment to evaluate the role that the CT plays in her overall pain pattern. Again, his expectation is for minimal relief. He will be surprised if she declares substantial improvement. The claimant was continued at work with restrictions.

4-18-11 MD., the claimant reports continued pain in the right arm. She has been working with restrictions. On exam, the claimant's wound is healing normally. The evaluator recommended therapy. Perform pre and post volumetric water displacement measurements.

5-16-11 MD., the claimant is work ing with restrictions. The claimant reported she had a Designated Doctor Evaluation who had specific recommendations, but Dr. had not received the report. The claimant's medications include Norco. The evaluator recommended therapy. Addendum: He reported that brought me her copy of OD report where the doctor makes a specific point of commenting on the direction of the trigger release incisions (surgeons with considerable experience In performing multiple trigger fingers have noted that longitudinal Incisions heal better than transverse incisions and most experienced hand surgeons use longitudinal Incisions). He states that "the profundus tendon has adherence" and recommends that the patient should have tenolysis surgery for this, he measured her motion again today as on multiple previous visits and the long finger his full excursion and ROM. He did not think that any conscientious hand surgeon I know would agree to take a patient to the OR for tenolysis of the digit with full range of motion. In fact to do so would likely constitute malpractice. He complains that he did riot receive a nerve test from the carrier. That is up to the carrier. The doctor says he doesn't understand what a water displacement volumetric measurement is.

11-17-11 Behavioral Evaluation notes the claimant was a candidate for a work hardening program.

11-17-11 Functional Capacity Evaluation shows the claimant is functioning at a Sedentary- Light PDL. Her job requires a Heavy PDL.

12-16-11, DC., noted was referred to our facility by her treating doctor, Dr., for a work conditioning program. The patient underwent an entrance Functional Capacity Evaluation on 11/17/11, which revealed her ability to perform at 'the Sedentary-Light physical demand level. The evaluation confirmed that: the claimant continues to demonstrate a functional performance deficit, as she has not reached the Heavy physical demand level required to fulfill her duties as a laborer. The patient's past medical history consist of medication, therapy, physical rehabilitation, injection therapy, and surgery. The FCE (on page 2) describes how the claimant has an inability to lift, carry, push, and pull as required by her occupational demands. The patient also demonstrates the inability to perform these tasks on a frequent basis per the dynamic lifting test (page 5). The pre-FCE questionnaire and physical therapy notes demonstrates the patient's difficulty with non-material handling, such as sitting, standing, walking, bending, reaching, climbing, squatting, kneeling, and crawling. The evaluator reported that the claimant has a position available to him as a laborer. However, she cannot return to work as her occupational demands exceeds her currant physical capabilities according to her functional capacity evaluation. Admission into a Work Conditioning program has been established as medically necessary based on the following facts:

- 1) She met DWC Treatment Guidelines entrance criteria for work conditioning.
- 2) Functional deficit has been demonstrated per an objective and valid evaluation on 11/17/11.
- 3) Work conditioning is considered a proper treatment intervention per the ODG Guidelines for this patient's injury.
- 4) A highly-structured work conditioning program has been recommended by the patients treating physician M.D.
- 5) Medical probability indicates the patient has a good prognosis of returning to work upon completion of the program.

12-22-11 MD., performed a UR. He noted that based on the clinical information submitted for this review and using the evidence-based, peer-reviewed guidelines referenced above, this request for 80 hours of right hand and wrist work hardening 97545 97546 is non-certified. Addendum: He received a return phone call on 12/22/11 at 4:58pm CST from Dr. who left a message for a return phone call. He called the number listed and discussed the case with Dr. who offered no additional information for consideration on this case.

1-2-12, DC., Request for reconsideration - work hardening 80 hours. The evaluator reported it is unfortunate that the physician advisor has not taken into consideration all of the indications for work hardening for this patient. The claimant needs to transition back to work at the Heavy PDL. Per an objective oriented FCE she is currently

functioning at the Sedentary-Light PDL. The very purpose of work hardening programs is to safely transition patients who have residual functional deficits, such as the claimant back into their previous job. The claimant has demonstrated good compliance and improvement with her treatment, and her progression has not plateaued. It is expected that she will continue to demonstrate further functional improvement through participation in a work hardening program. Prior to the patient's injury, she was conditioned to perform her job effectively; however, since the onset of her injury she has become deconditioned. During her participation in the work-hardening program, she will perform body-conditioning activities and job specific work simulation activities that parallel those activities required by her job. Upon completion of work hardening program, the claimant will transition back into her previous job; position. Denial of the requested treatment interferes with the claimant's progression and her ability to return to work. He concluded that: "It is unfortunate that the clinical facts indicating the medical necessity of work hardening for this patient were not considered at the time of the initial request. Medical probability indicates that the claimant has a great potential to benefit from the work hardening program. As a result, it is his professional duty to respectfully request reconsideration for 20 hours of work hardening for the claimant, which will allow us to return her to unrestricted work duty and achieve case resolution."

1-10-12 MD., performed a UR. He noted that based on peer reviewed guidelines, the appeal for 80 hours of work hardening to the right hand/wrist 97546 WH 97547 WH is non certified.

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

After review of the presented documentation as well as the ODG Work Hardening Guidelines referenced below, the request for 80 hours of Work Hardening is medically reasonable and necessary. The Functional Capacity Evaluation showed the claimant has functional deficits. She is deconditioned and the plan is for her to transition back to her pre-employment job. Therefore, based on the records provided, the request for Work hardening 80 hours right hand/wrist 97545 WH 97546 WH is reasonable and medically necessary.

ODG-TWC, last update 2-20-12 Occupational Disorders - Pain: Work Hardening/Work 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 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 KNOWLEDGBASE**
- 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)