



CLAIMS EVAL

*Utilization Review and
Peer Review Services*

Notice of Independent Review Decision-WC

CLAIMS EVAL REVIEWER REPORT - WC

DATE OF REVIEW: 3-21-12

IRO CASE #: 39963

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

80 hours work hardening

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 or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- 11-10-10 EMG/NCS performed by
- 12-21-10 office visit
- 1-11-11 office visit
- 1-12-11 basic exam
- Follow up with on 1-14-11
- Follow up with on 1-17-11
- Follow up with on 1-18-11
- Follow up with on 1-24-11
- Follow up with on 1-26-11
- 3-24-11 MRI of the right shoulder
- 4-21-11 CT scan
- 4-21-11 right shoulder arthrogram with post-arthro graphic CT
- 4-21-11 CT scan of the right shoulder
- 5-2-11 progress note
- 7-11-11 hand written notes
- 12-19-11 performed a Peer Review.
- 1-6-12 Physical Performance Evaluation.
- 1-11-12 Work hardening plan and treatment goals and recommendations.
- 1-11-12 Initial Behavioral Consultation performed by
- 1-11-12 office visit.
- 2-8-12 Work hardening treatment request.
- 2-13-12 UR performed by
- 3-2-12 UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

11-10-10 EMG/NCS performed by shows right sided motor neuropathy. Right ulnar motor neuropathy across the elbow. No evidence of sensory polyneuropathy, peripheral neuropathy or cervical radiculitis or radiculopathy.

12-21-10 performed a right shoulder arthroscopy with subacromial decompression and acromioplasty, repair of SLAP lesion, removal of adhesions, joints synovectomy, and an open rotator cuff repair.

1-11-11 the claimant reports her neck pain is slightly improved. In addition, she states that the shoulder pain has been a little better since the last visit. She also states that the elbow pain is showing a slight amount of improvement. Finally, she reports that there has been a modest amount of improvement in the right hand pain. Functional motion was checked and there was moderate fixation of the spinal joints at C1-C3, a severe degree of joint fixation at C3, C6, C7, C8, and T2 noted. Examining the spinal tissues by palpation revealed a severe intensity of pain at T1 and T3-T5 on the right and C1-C3 and C5-C8 and T2 bilaterally. A mild degree of swelling at T1-T5 on the right, moderate edema at T2 on the left and C1-C3 and C5-C8 bilaterally was found. Tonicity of the muscles was tested and complete spasm of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally was found. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified and spasm of muscle. The claimant was provided with therapy.

1-12-11 the claimant reports that the elbow pain is showing a slight amount of improvement. Functional motion was checked and there was a moderate amount of spinal joint fixation at C1-C3, severe joint restriction at C5, C6, C7, C8, and T2 noted. A minor degree of swelling at T1-T5 on the right, a medium quantity of swelling at T2 on the left and C1-C3 and C5-C8 bilaterally was elicited. The muscles showed severe spasticity of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified and spasm of muscle. The claimant was provided with therapy.

Follow up with on 1-14-11, the claimant states she is feeling slightly better in the neck area. She also states that the shoulder pain is slightly improved. Additionally, she states the elbow pain is slightly improved and that there has been a modest amount of improvement in the right hand pain. Spinal evaluation revealed a moderate loss of joint function at C1- C3, a severe degree of joint fixation at C3, C6, C7, C8, and T2. A strong pain level at T1 and T3-T5 on the right and C3-C5-C8 and T2 bilaterally was exhibited on palpation of the vertebral segments and the surrounding tissue. A mild degree of swelling at T1-T5 on the right, edema of a moderate degree at T2 on the left and C1-C3

and C5-C8 bilaterally was found. Palpation revealed spasm of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified, and spasm of muscle. The claimant was provided with therapy.

Follow up with on 1-17-11 the claimant states she is feeling slightly better in the neck area. She also states that the shoulder pain is slightly improved. Additionally, she states the elbow pain is slightly improved and that there has been a modest amount of improvement in the right hand pain. Functional motion was checked and there was a moderate degree of fixation at C1- C3, a severe degree of joint fixation at C5, C6, C7, C8, and T2. A strong pain level at T1 and T3-T5 on the right and C3-C5-C8 and T2 bilaterally was exhibited on palpation of the vertebral segments and the surrounding tissue. A mild degree of swelling at T1-T5 on the right, a medium quantity of swelling at T2 on the left and C1-C3 and C5-C8 bilaterally was found on palpation of the spinal tissues. Tonicity of the muscles was tested and spasm of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally was found. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified, and spasm of muscle. The claimant was provided with therapy.

Follow up with on 1-18-11 the claimant states that there is a slight improvement in the degree of neck pain. Also, the shoulder pain has been a little better since the last visit. Additionally, she states that the elbow pain is showing a slight improvement. She reports that she is experiencing a slight decrease of pain and discomfort of her right hands. On palpation examination of the spinal segments moderate fixation of the spinal joints at C1-C3, a severe amount of fixation at C5, C6, C7, C8 and T2 was present. A severe intensity of pain at T1 and T3-T5 on the right and C1-C3, C5-C8 and T2 bilaterally was found on palpation of the spine. Digital inspection of the spinal tissues revealed mild swelling at T1-T4 on the right, a medium degree of edema at T2 on the left and C1-C3 and C3-C8 bilaterally. Evaluation of the muscles showed severe spasticity of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified, and spasm of muscle. The claimant was provided with therapy.

Follow up with on 1-24-11, the claimant states she is feeling a slight improvement in the condition of cervical pain. She also states that the shoulder pain is slightly improved. Additionally, she states that the elbow pain has been feeling slightly better. And finally, she states that there has been a mild degree of reduction in the pain of her right hand. The exam shows moderate fixation of the spinal joints at C1-C3, a severe amount of fixation at C5, C6, C7, C8 and T2 was present. A severe intensity of pain at T1 and T3-T5 on the right and C1-C3, C5-C8 and T2 bilaterally was found on palpation of the

spine. In the spinal tissues, palpation revealed mild swelling at T1-T5 on the right, moderate swelling at T2 the left and C1-C3 and C3-C8 bilaterally. Evaluation of the muscles showed severe spasticity of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified, and spasm of muscle. The claimant was provided with therapy.

Follow up with on 1-26-11, the claimant states she is feeling a slight improvement in the condition of cervical pain. She also states that the shoulder pain is slightly improved. Additionally, she states that the elbow pain has been feeling slightly better. And finally, she states that there has been a mild degree of reduction in the pain of her right hand. The exam shows moderate fixation of the spinal joints at C1-C3, a severe amount of fixation at C5, C6, C7, C8 and T2 was present. A severe intensity of pain at T1 and T3-T5 on the right and C1-C3, C5-C8 and T2 bilaterally was found on palpation of the spine. In the spinal tissues, palpation revealed mild swelling at T1-T5 on the right, moderate swelling at T2 the left and C1-C3 and C3-C8 bilaterally. Evaluation of the muscles showed severe spasticity of the upper thoracic muscles and mid thoracic muscles on the right and suboccipital muscles and cervical paraspinal muscles bilaterally. Diagnosis shows displacement of the cervical intervertebral disc without myelopathy. Disorders of Bursae and tendons in shoulder region, unspecified. Carpal tunnel syndrome. Neuralgia, neuritis, and radiculitis, unspecified, and spasm of muscle. The claimant was provided with therapy.

3-24-11 MRI of the right shoulder shows there are large areas of metallic susceptibility artifact from this patient's previous right shoulder surgery. The degree of metal artifact limits the evaluation of the distal rotator cuff. There is a small joint effusion present. The right axilla is unremarkable. Impression: Markedly limited MRI examination of the right shoulder from metallic susceptibility artifact due to this patient's previous surgery. Consider a CT shoulder arthrogram for further evaluation. Small right glenohumeral joint effusion.

4-21-11 CT scan of the right shoulder revealed recurrent full-thickness rotator cuff tear status post rotator cuff repair.

4-21-11 preoperative diagnosis: Internal derangement right shoulder status post previous surgery. Postoperative diagnosis: Internal derangement right shoulder status post previous surgery. Procedure: Right shoulder arthrogram with post-arthro graphic CT.

4-21-11 CT scan post arthrogram of the right shoulder shows contrast extends from the glenohumeral joint into the subdeltoid subacromial bursa through a 2 x 2.5 cm full-thickness rotator cuff tear. There is mild supraspinatus muscle atrophy. Two anchors are seen in the greater tuberosity from previous rotator cuff repair. There is a type II acromion without acromioclavicular degenerative disease. Impression: Mild

supraspinatus muscle atrophy and recurrent full-thickness rotator cuff tear status post rotator cuff repair. Correlation with previous surgical records is recommended. No other glenohumeral joint abnormalities.

5-2-11 progress note. The claimant complains of right shoulder pain and is unable to fully raise arm. The evaluator notes the right shoulder AROM is 0-90 degrees. The rotator cuff strength is 2/5. CT arthrogram shows recurrent rotator cuff tear. The evaluator recommended a CT arthrogram. Impression: Rotator cuff tear.

7-11-11 hand written notes refer the claimant has diffuse right shoulder tenderness. She was found to have cancer in her uterus. She was scheduled to have surgery.

12-19-11 performed a Peer Review. He reported has recurrent full thickness rotator cuff tear, was to have surgery, though the 7/21/11 office visit note identified that she had been diagnosed with uterine cancer and was to undergo treatment for that. There were no additional office visit notes after that date. There were only continued DWC 73s continuing the claimant off work. There is no additional active therapy, DME products, ongoing office visits that would be reasonable at this time unless the claimant is on prescription medications not identified in these medical records. Follow up with the orthopedic surgeon for an acute flare up in shoulder symptoms would be reasonable. Future treatment in regards to right shoulder cannot be anticipated as this would depend on future symptoms, and whether or not the claimant has recovered from cancer if. It is not medically probable that the claimant will be a candidate for work hardening or pain management. ODG would support cortisone injection in the shoulder depending on future symptoms. Occasional use of an opioid such as Norco would be reasonable at low dose if effective for acute flare up in shoulder symptoms. It is not medically probable that the other symptoms in the right upper extremity were produced by the 9/20/10 work event or resultant right shoulder surgery and thus no additional treatment would be causally related for those symptoms.

1-6-12 Physical Performance Evaluation.

1-11-12 Work hardening plan and treatment goals and recommendations.

1-11-12 Initial Behavioral Consultation performed by assessment: AXIS I: Pain disorder associate with both psychological factors and a general medical condition, choric. AXIS II: No diagnosis. AXIS III: Injury to right upper extremity. AXIS IV: Problems related to primary support group: economic, occupational and educational issues. AXIS V: GAF: 61, estimated pre injury: 80+. Recommendations: The claimant is an excellent candidate for a work hardening program.

1-11-12 The claimant complains of some numbness in her right snuffbox region. Her diagnosis is a right arm and hand strain and right elbow cubital tunnel syndrome and right rotator cuff tear. Plan: Begin work hardening program.

2-8-12 Work hardening treatment request notes the claimant states that she sustained a work-related injury to her right upper extremity on xx/xx/xx while performing her customary duties for whom she had worked for nearly x years at the time of the injury. The claimant explained that she was reaching/twisting backwards with her dominant right arm to place the tiles in a metal cart when she felt a sharp pain in her right shoulder and stopped the line so she could report the injury to her supervisor. Since that time patient reports undergoing the following: physical therapy, X-rays, MRI, injections, and right shoulder arthroscopy with subacromial decompression and acromioplasty, repair of SLAP lesion, removal of adhesions, joints synovectomy, open rotator cuff repair with on 12/21/10. CT of the right shoulder performed on 4/21/11 revealed recurrent full-thickness rotator cuff tear status post rotator cuff repair. treating physician is recommending that the patient be progressed to a work hardening program due to the patient's persistent functional deficits, which are impeding his ability to make a safe return to work on full duty. Results of the Beck Depression Inventory-II (BDI-II) and the Beck Anxiety Inventory (BAI) reveal the following: The patient scored 18 on the BDI-II, indicating mild depression. The patient's score on the BAI was 11, reflecting mild anxiety. Her responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ- W = 34) as well as significant fear avoidance of physical activity in general (FABQ-PA = 21). When asked to rate targeted symptoms on a scale of 1 to 10. The Functional Capacity Evaluation performed on 01/06/12 reveals the patient is functioning at a SEDENTARY-LIGHT PDL and the job requires a MEDIUM PDL. The claimant has shown modest improvement with outpatient physical therapy modalities and we are now recommending progression to a Work Hardening Program for progress to continue to be achieved. It is clear from the functional capacity evaluation that the current level of functioning due to injury interferes with the patient's ability to safely carry out specific tasks required at their workplace without risk of further injury and/or aggravation of the condition. 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. The patient is currently not working. The patient is likely to meet the required PDL to safely return to work with this program. The patient will be evaluated on a regular basis, and it is our expectation that they will return to pre-injury work status upon completion of the program. They expected they will regain full-duty status upon completion of the program.

2-13-12 UR performed by notes he discussed this case and requested procedure with 2-13-11 01:15 PM CT. He did not recommend certification of 10 sessions/80 hours of work hardening. Recommendation: Non-certification is recommended for the following reasons: The mental health evaluation of 1/11/12 finds impression of pain disorder. However, the utilized psychometric instruments (limited to BAI, BDI, FABQ) are inadequate/inappropriate to elucidate the pain problem, explicate psychological dysfunction, or Inform differential diagnosis in this case; and there is no substantive behavior analysis to provide relevant clinical/diagnostic information (ACOEM. (2008), Chronic pain, Occupational Medicine Practice Guidelines, 2nd ed.; o. 319-3201. Moreover, the employed psychological tests do not have established peer reviewed, post-market reliability, empirical validity (concurrent or predictive) and normative data to render appropriate sensitivity and specificity for assessment and diagnosis of patients

with this type of presentation. Therefore, this renders the interpretations questionable; they do not serve as basis for informing differential diagnosis; and an inflated estimate of reported distress and dysfunction may be inferred. Clinically meaningful verbal and nonverbal pain behavior is now reported, although (remarkably) it was not reported in the above evaluation. Such often constitutes a negative prognosis in work hardening [Petersen, M. (1995). Nonphysical factors that affect work hardening success: A retrospective study, *Journal of Orthopaedic & Sports Physical Therapy*, 22(5), 28-246]. The patient is doing a home exercise program; and there is no documentation that the patient has "plateaued" in this regard. There is also no documentation vis-a-vis the cortisone injections recommended by the treating physician. There is no documentation or known finding that the patient's treating physician has currently ruled out all other appropriate care for this problem, a pivotal indication for initiating work hardening. His only request of the current provider appears to be "evaluate and treat". The mental health report offers that the medical history is "unremarkable" and history and exam of 1-11-12 contains no review of systems, and the only indicated PMH is anemia. There is no allusion to the below uterine CA or how this has affected the patient psychologically or behaviorally. He was not able to establish a basis that this treatment is both reasonable and necessary at this time. Non-approval is recommended.

3-2-12 UR performed by notes the available information does not provide the necessary rationale for the medical necessity of 80 hours of work hardening. Regarding the psychological evaluation, the report of the preauthorization request does include data to suggest significant psychological and emotional issues for the patient. In the ODG criteria for participation in a work hardening program, it states, "The testing should 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 the work hardening program" The information provided does not address this issue. In a report of a peer review provided by on 12-19-2011, he reviewed the available medical records and opined that it is not medically probable that the claimant will be a candidate for work hardening or pain management. What is more even more pertinent, indicated that ODG would support cortisone injection in the shoulder depending on future symptoms. opinion would be in contrast to ODG criteria for work hardening participation that states, "The patient is not a candidate for whom...injections...clearly be warranted to improve function." In addition, in report that pertained to review of medical records, wrote, " saw the claimant on 7-12-11 for continued right shoulder pain. She noted that she was unable to have surgery now because she was found to have cancer of the uterus and was having surgery for the next week." later wrote in the report regarding treatment options, "Future treatment in regards to right shoulder cannot be anticipated as this would depend on future symptoms, and whether or not the claimant has recovered from cancer." Per ODG regarding criteria for participation in a Work Hardening Program, it is written, "There is no evidence of other medical, behavioral, or other comorbid condition (including the that are non work-related) that prohibits participation in the program or contradicts successful return-to-work, upon program completion." The pre-authorization on 2-8-2012 does not mention the patient's cancer status. The available information

does support a rationale for participation in a work hardening program and the request is therefore non-certified.

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

There does not appear to be sufficient documentation presented to support the request for 80 hours of Work Hardening. The claimant has psychological issues which are unrelated to the work related injury. Therefore, the request for 80 hours Work Hardening is not reasonable or medically necessary.

ODG-TWC, last update 2-29-12 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 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)**