CASEREVIEW

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Notice of Independent Review Decision

DATE OF REVIEW: February 23, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 hours of a work hardening program

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified Physical Medicine and Rehabilitation with over 15 years of experience.

REVIEW OUTCOME:

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

☒ Overturned (Disagree)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
12/19/11: Initial Behavioral Medicine Consultation from
12/19/11: Functional Capacity Evaluation from
12/19/11: Multidisciplinary Work Hardening Plan & Goals of Treatment from created by
12/29/11: History and Physical by
01/06/12: Work Hardening Program Pre-Authorization Request from
01/11/12: UR performed by
01/16/12: Reconsideration: Work Hardening Program from
01/20/12: UR performed by

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was working and as he turned, he heard a “pop” and felt a sudden onset of pain in his low back on xx/xx/xx.

On December 19, 2011, the claimant had an initial behavioral medicine consultation at at the directive of. It was noted the claimant rates his pain on a scale of 1-10, an 8. The claimant reported no prior surgeries, but had a heart attack in 2001 or 2002 and takes daily medications for his heart condition. It was reported that the claimant had been off work since his employer will not accept him back with restrictions. The claimant rated his level of overall functioning in life prior to the injury at 85% and rates his current level of functioning at 35-40%. It was reported that his mood was slightly anxious while his affect was slightly constricted. His responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work, (FABQ-W=37) as well as significant fear avoidance of physical activity in general (FABQ-PA=17). Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition, acute. Axis II: no diagnosis. Axis III: Injury to low back. Axis IV: Primary support group, occupational, economic, and educational problems. Axis V: GAF-Current: 62; Estimated pre-injury: 81+. Summary: The claimant has undergone conservative treatment including physical therapy and an ESI, but continues to struggle with pain complaints, functional problems, and fear avoidance behaviors that pose difficulty to his performance or routine demands of living and occupation function. The claimant’s treating doctor is recommending participation in an interdisciplinary return to work program to advance the claimant’s physical condition and functioning and support the claimant’s desire to return to work. “The patient would be an excellent candidate for the Work Hardening Program”. A Baseline and Treatment Goal grid was provided.

On December 19, 2011, the claimant underwent a Functional Capacity Evaluation at. It was reported that the claimant was currently not working, but his job would be available or he would be allowed to re-apply for his previous position. The current job description was listed in the Heavy PDL. Based on the results of the evaluation it was determined that the claimant could not safely perform his job demands and he performed at the Sedentary PDL.

On December 19, 2011, there was a Multidisciplinary Work Hardening Plan & Goals of Treatment from. Goals of Treatment: Increase work endurance, tolerance, and return to gainful employment. Decrease anxiety, decrease depression, increase an internal locus of control, resolve return to work barriers, and move forward to case closure. Physical Therapy will include: Formalized PT/OT evaluation and FCE prior to program entry, extremity strengthening, core spinal stability training, stabilization, postural awareness, and balance training, strengthening/conditioning of the abdominal and Paraspinals, passive and active stretching, sitting/standing tolerance, neuromuscular reduction, work simulation, biomechanics, ergonomic training, isometrics, and kinetic training, free-weight and universal gym training, aerobic conditioning, and ADL training. The patient will receive PT/OT Discharge Evaluation with MMI, work restrictions, and ROM measurement at the completion of a 20-30 day program.

On December 29, 2011, the claimant was evaluated by for evaluation for possible work hardening program. The claimant had a history of cardiac problems but was stable. He denied any chest pains or shortness of breath. He takes heart and blood pressure medications on a regular basis. The claimant felt he could undergo the program. Impression: Lumbar sprain, and medical history of hypertension, coronary artery disease and congestive heart failure. Plan: Patient is currently medically stable to initiate the work hardening program.

On January 6, 2012, a Work Hardening Program Pre-Authorization Request was submitted by. It was included in the report that the claimant had received approximately 8 sessions of physical therapy with 2 sessions remaining. A MRI of the lumbar spine without contrast on 07/16/11 revealed: a 1mm lateralizing disc bulge at L2-3 resulting in mild left neural foraminal stenosis, a 2mm lateralizing disc bulge and facet hypertrophy at L3-4 resulting in mild bilateral neural foraminal stenosis, a 2mm diffuse disc bulge with facet hypertrophy at L4-5 with mild left neural foraminal stenosis and moderate right neural foraminal stenosis, and a 2 mm broad-based central disc protrusion with facet hypertrophy at L5-S1 with severe right neural foraminal stenosis and severe left neural foraminal stenosis at the medial aspect. On 09/15/11 patient received a caudal epidural steroid injection with that patient reports helped him for about a week and a half. At the present time, has recommended that participate in a Work Hardening Program since he is not a good candidate for surgery due to his medical condition. It was reported that his FABQ-W = 37, which indicated significant fear avoidance of work as well as a FABQ-PA = 17 which indicated significant fear avoidance of physical activity in general. It was documented that the FCE performed on 12/19/11 revealed the claimant was functioning at a Sedentary PDL and the job requires a Heavy PDL. It was reported that the claimant had shown modest improvement with outpatient physical therapy modalities and they were now recommending progression to a WHP for progress to be continued. It was noted that they expected the claimant to regain full-duty status upon completion of the program.

On January 11, 2012, performed a UR on the claimant. Rationale for Denial: The request for work hardening is not supported in the ODG. The patient has no objectively defined spinal pathology of occupational etiology to support the ongoing subjective complaints, sedentary PDL or a work hardening program. Work hardening programs are not medically necessary strictly for ongoing subjective complaints of back pain after a soft tissue strain that occurred 7 months prior and would have reasonably resolved within a matter of weeks. Psychometrics performed are inadequate to rule out a primary psychiatric disorder, personality disorder, somatization and/or malingering. I spoke with. Case was discussed. Recommendation is unchanged.

On January 16, 2012, submitted Reconsideration for the Work Hardening Program. In response to denial, wrote: diagnosis is lumbar sprain/strain and radiculopathy. A simple sprain/strain would not have qualified for an injection. Also his MRI reveals abnormalities. We do not think that this gentleman is malingering/or somatizing and he does not require formal psychological testing to rule out a psychiatric disorder or personality disorder. did report that the claimant stated he was a very determined

person and hopes to get better so he could return to work since he misses it. He had been off work since June 2011 since his employer would not allow him to return with restrictions, but he does have a job to return to. It was also noted he completed 10 sessions of Physical Therapy.

On January 20, 2012, performed a UR on the claimant. Rationale for Denial: The provided documentation does not support the request for a work hardening program. The FCE does not demonstrate a valid deficit. The physiologic monitoring that was performed is not consistent with max effort. There was no evidence for instance that he reached at least 75% of submaximal heart rate. Further, the FCE was misinterpreted as showing a sedentary level. He performed over a 50 pound leg lift which is not sedentary. I discussed the case with. We paid particular attention to the FCE. He did not provide any additional information that would validate the FCE. Additionally as noted, the patient performed over a 50 pound lift which is not sedentary.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:
Denial of 80 hours work hardening is overturned/disagreed with. Questions of validity regarding submaximal heart rate/testing may be explained by various medication for other comorbidities for which he has cardiac clearance. And even if there is disagreement in classification of current physical capabilities, a 50 pound leg lift is still only a Medium PDL which is less than claimant's Heavy job demands. Therefore, along with physical exam, psychometric testing, treatment goals and a job to return to, ODG criteria for work hardening are met.

ODG:
Criteria for admission to a Work Hardening (WH) Program:
(1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a prescription has been provided.
(2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components: (a) History including demographic information, date and description of injury, history of previous injury, diagnosis/diagnoses, work status before the injury, work status after the injury, history of treatment for the injury (including medications), history of previous injury, current employability, future employability, and time off work; (b) Review of systems including other non work-related medical conditions; (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or physical and/or occupational therapist (and/or assistants); (d) Diagnostic interview with a mental health provider; (e) Determination of safety issues and accommodation at the place of work injury. Screening should include adequate testing to determine if the patient has attitudinal and/or behavioral issues that are appropriately addressed in a multidisciplinary work hardening program. The testing should also be intensive enough to provide evidence that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs, or will likely prevent successful participation and return-to-employment after completion of a work hardening program. Development of the patient's program should reflect this assessment.
(3) *Job demands:* A work-related musculoskeletal deficit has been identified with the addition of evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands are generally reported in the medium or higher demand level (i.e., not clerical/sedentary work). There should generally be evidence of a valid mismatch between documented, specific essential job tasks and the patient's ability to perform these required tasks (as limited by the work injury and associated deficits).
(4) *Functional capacity evaluations (FCEs):* A valid FCE should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate

capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs.
(5) *Previous PT:* There is evidence of treatment with an adequate trial of active physical rehabilitation with improvement followed by plateau, with evidence of no likely benefit from continuation of this previous treatment. Passive physical medicine modalities are not indicated for use in any of these approaches.
(6) *Rule out surgery:* The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further diagnostic evaluation in anticipation of surgery).
(7) *Healing:* Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
(8) *Other contraindications:* There is no evidence of other medical, behavioral, or other comorbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.
(9) *RTW plan:* A specific defined return-to-work goal or job plan has been established, communicated and documented. The ideal situation is that there is a plan agreed to by the employer and employee. The work goal to which the employee should return must have demands that exceed the claimant's current validated abilities.
(10) *Drug problems:* There should be documentation that the claimant's medication regimen will not prohibit them from returning to work (either at their previous job or new employment). If this is the case, other treatment options may be required, for example a program focused on detoxification.
(11) *Program documentation:* The assessment and resultant treatment should be documented and be available to the employer, insurer, and other providers. There should 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)**