

CASEREVIEW

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 5, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening Program 5 x a week x 2 weeks 97545 97546

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 16 years of experience.

REVIEW OUTCOME:

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

Upheld (Agree)

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was involved in a work related accident on xx/xx/xx. She was wearing a seatbelt. She was sitting in traffic, not moving, when a car hit her van from behind. She was taken by EMS to Emergency Department where she was released to self-care. Later that evening she returned to Hospital due to confusion and was diagnosed with a concussion.

On May 21, 2012, the claimant was evaluated by MD for left sided neck pain, right shoulder pain, and low back pain radiating into her right lower extremity. On physical examination her neck had full ROM but she did exhibit tenderness when tested in opposition on the left side. Her upper extremities had full ROM and good strength when tested in opposition. Her lumbar spine had significant myospasms with myositis on the right side with decrease active and passive ROM secondary to the pain and discomfort. Her straight leg raise was weak on the right and her deep tendon reflexes were equal bilaterally and she had 2+ tenderness over the

SIJ's. Impression: 1. Cervical sprain/strain. 2. Lumbar sprain/strain. 3. Right shoulder sprain/strain. 4. Right lumbar radiculopathy. 5. Rule out lumbar herniated disc. Plan: Request PT consult.

On June 1, 2012, MRI of the Lumbar Spine, Impression: Mild spondylosis only. No neural compression or compromise or instability.

On June 4, 2012, the claimant underwent an initial rehab evaluation at xxxx xxxx. Current medications were listed as Flexeril and Tramadol. Pain Rating was 2/10. ROM of the cervical was: Flexion 35 degrees, extension 40 degrees, left lateral flexion 40 degrees, right lateral flexion 35 degrees, left rotation 80 degrees, and right rotation 75 degrees. ROM of the lumbar was: Flexion 60 degrees, extension 20 degrees, left lateral flexion 15 degrees, and right lateral flexion 15 degrees. Plan: The patient would be seen for rehab therapy consisting of an active care program with passive care performed on a p.r.n. basis.

On July 5, 2012, the claimant was re-evaluated by MD for continued pain and tenderness on the right side of her lower back. She reported the pain in her neck and right shoulder had resolved. It was reported she had completed 8 sessions of PT with significant improvement and showed marked pain relief with the TENS unit during physical therapy. On physical exam she had moderate spasm and tenderness on the right para lumbar musculature and increased pain with flexion extension and lower back on the right as well. Neurologically was nonfocal and she had good strength in lower extremities, deep tendon reflexes were symmetric, and she showed no neuropathy or paresthesias. Assessment: 1. Cervical sprain/strain. 2. Lumbar sprain/strain. 3. Right shoulder sprain. Plan: Tens unit for her lower back, change prescription for Flexeril to just one at night, and Psych eval because of her high frustration levels.

On July 11, 2012, the claimant underwent an initial behavioral medicine consultation to assess her emotional status and to determine the relationship to the work accident. Vocational Status: Return to work at the same position with the same employer. Present Medications: Flexeril 10 mg. Goal is to titrate medications. Description of Pain: present pain level was 8/10, average pain level 5/10. It was reported the pain interferes with recreational, social, and familial activities. Lifestyle Changes: The claimant reported difficulty with acts of daily living to include household chores, yard work, exercising/playing sports, driving or sitting for more than 2 hours, standing more than 3 hours, walking more than .5 miles, bending, squatting, lifting/carrying more than 10 pounds, and sexual activity. She described she was less involved in family activities and less participation in social outing. She endorsed sleep maintenance insomnia (difficulty falling asleep and 1 awakening throughout the night due to pain.) She reported her level of overall functioning prior to her injury as 80% and her current level as 20%. The claimant quantified her symptoms numerically as the following: pain level 7/10, irritability and restlessness 3/10, frustration and anger 2/10, muscle tension/spasm 4/10, nervousness and worry 1/10, sadness and depression 1/10, sleep disturbance 5/10, and forgetfulness 1/10. On the BDI-II she scored an 11, indicating minimal depression. On the BAI, she scored 20 reflecting moderate anxiety. FABQ-W = 25, which is non-significant and significant fear avoidance of physical activity in general FABQ-PA=21. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a

general medical condition; acute. Anxiety disorder. Axis II: no diagnosis. Axis III: Injury to cervical and lumbar. Axis IV: Primary, economic and occupational. Axis V: GAF Current = 68, GAF Estimate Pre-Injury = 85+. Treatment Goals were presented. Plan: Recommendation that the claimant participate in the Work Hardening Program.

On July 17, 2012, the claimant underwent an FCE. Based on the test results her problems are continued pain, decreased strength, decreased AROM and decreased functional tolerance. Per Dept of Occupation Titles her occupation is in the Medium PDL. She tested at a LIGHT PDL and did not meet her full time duty occupation requirements. Recommendations: The patient would benefit from a 10 day trial in the Work Hardening Program.

On July 19, 2012, the claimant was re-evaluated by MD who on physical examination found moderate pain with range of motion of her lumbar spine to flexion, extension and rotation. She had diffused tenderness in the lumbar spine with any ROM. She had pain with motion of her right shoulder. She also had moderate pain to palpation over the left side of her neck and the left paracervical musculature to flexion, extension. Plan: Work hardening program and PT for her shoulder.

On August 13, 2012, the claimant underwent an FCE. Based on the test results she tested at a LIGHT- MEDIUM PDL and did not meet her full time duty occupation requirements. Recommendations: The patient would benefit from an additional 10 days in the Work Hardening Program.

On August 13, 2012, the claimant underwent a reassessment for work hardening program continuation. Results of Assessment Utilized: FABQ-W was 25, currently 25 (no change); FABQ-PA was 21, currently 18 (slight decrease); BDI-II was 11, currently 10 (slight decrease); BAI was 20, currently 27 (significant increase); VAS Pain was 7, currently 6 (slight decrease); Irritability was 3, currently 5 (slight increase); Frustration was 2, currently 2 (no change); Muscle Tension was 4, currently 5 (slight increase); Anxiety was 1, currently 1 (no change); Depression was 1, currently 1 (no change); Sleep Problems was 5, currently 8 (increase); Forgetfulness was 1, currently 1 (no change); Average hours slept was 3-4, currently 3-5 (no real change). Present medications now Norco 5-325 mg and Flexeril 10 mg. Multiaxial Diagnosis: Axis I: Pain disorder associated with both psychological factors and a general medical condition; acute. Anxiety disorder. Axis II: no diagnosis. Axis III: Injury to cervical and lumbar. Axis IV: Primary, economic and occupational. Axis V: GAF Current = 69, GAF Estimate Pre-Injury = 85+. Vocational status/plan: She is currently working for the same company with restrictions and goal is to return to work at the same position with the same employer. Recommendation/Plan: Continue to participate in a Work Hardening Program to further increase her physical and functional tolerances and to facilitate a safe and successful return to work.

On August 27, 2012, MD performed a UR. Rationale for Denial: The patient has completed 80 hours of the program to date without significant improvement. FABQ-W remains 25. FABQ-PA decreased from 21 to 18. DBI decreased from 11 to 10 and BAI increased from 20 to 27. Pain level decreased from 7 to 6. Current medications are listed as Norco and Flexeril. Irritability increased from 3

to 5/10, frustration remained 2/10, tension increased from 4 to 5/10, anxiety remained 1/10, depression remained 1/10, sleep disturbance increased from 5 to 8/10 and forgetfulness remained 1/10. The submitted records indicate that prior to the program the patient's only medication was Flexeril and after 80 hours in the program the patient is now taking Norco as well. I discussed the case with Dr.. The request is not medically necessary. Patient placed on Norco during WH and given the fact the patient has to drive, this med is not appropriate to get the patient back to work.

On September 6, 2012, there is a pre-authorization request from xxxxx that address Dr. denial of the additional work hardening. It was reported that the claimant was asked about her medication usage and stated that she was not taking the Norco. She had been prescribed them, but would not take them because she is a driver. On 8/6/12 she had a toxicology urine screen which was negative for opioids. In response to Dr. stating the claimant completed 80 hours of Work Hardening without significant improvement, it was argued that the claimant did make gain in the work hardening program. It was pointed out that based on her FCE's she did make many physical gains, including increased hand grip strength, pinch strength, hip abduction strength, hip extension strength, hip flexion strength, static strength, box carry, floor to waist lift, waist to shoulder lift and chest to overhead lift. Her Pre-WH PDL was Light and Current PDL is Light-Medium with a required PDL of Medium. It was also pointed out that ODG define Functional Improvement not only by "improvement of function", but also by "maintenance of function that would otherwise deteriorate." In response to the claimant reporting an increase in irritability, muscle tension/spasm, and sleep disturbance, they indicated that ODG says 'patients may get worse before they get better'.

On September 17, 2012, DO performed a UR. Rationale for Denial: There is no additional persuasive clinical data provided to support a change in determination. The submitted records indicate that the patient also has a diagnosis of lupus. Per telephonic consultation with Dr, he noted the patient has not been responding to the initial work hardening. Although scores are not significantly changed, he does feel the patient's response to treatment to date supports continued treatment.

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

Denial of additional work hardening 5 days a week for 2 weeks is agreed upon/upheld. Per ODG Pain chapter, there is lack of documented subjective and objective improvement after 80 hours of work hardening. Therefore the request for a Work Hardening Program 5 x a week x 2 weeks 97545 97546 is found to be not medically necessary.

PER 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)**