

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: October 12, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97545 Work Conditioning x80 Hours, 97546 Work Conditioning Add-On

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:

07-15-11: Visit Summary

07-15-11: Notice of Disputed Issue(s) and Refusal to Pay Benefits

07-16-11: Associate Statement – Workers Compensation completed, Claimant

07-18-11: Texas Workers' Compensation Work Status Report

07-19-11: Initial Medical Report

07-19-11: Texas Workers' Compensation Work Status Report

07-19-11: Visit Summary

07-19-11: Texas Workers' Compensation Work Status Report

07-20-11: Evaluation

08-03-11: Office Visit dictated

08-03-11: Texas Workers' Compensation Work Status Report

08-04-11: Daily Progress Note

08-16-11: Consultation Note

08-22-11: Initial Plastic Surgery Consultation and Examination

08-22-11: Texas Workers' Compensation Work Status Report
09-07-11: Office Visit
09-07-11: Texas Workers' Compensation Work Status Report
09-14-11: Office Visit
09-22-11: Work Capacity Evaluation
09-29-11: Designated Doctor Evaluation
10-19-11: Texas Workers' Compensation Work Status Report
11-30-11: Office Visit
12-13-11: IRO performed
12-22-11: Subsequent Medical Report
12-22-11: Work Capacity Evaluation
12-22-11: Texas Workers' Compensation Work Status Report
01-30-12: EMS Prescription & Statement of Medical Necessity
01-31-12: Subsequent Medical Report
01-31-12: Texas Workers' Compensation Work Status Report
02-07-12: Subsequent Medical Report
03-08-12: Subsequent Medical Report
03-08-12: Work Capacity Evaluation
03-08-12: Texas Workers' Compensation Work Status Report
04-19-12: Subsequent Medical Report
04-19-12: Texas Workers' Compensation Work Status Report
04-23-11: Subsequent Medical Report
06-19-12: Texas Workers' Compensation Work Status Report
06-21-12: EMS Prescription & Statement of Medical Necessity
07-06-12: Designated Doctor Evaluation
07-06-12: Texas Workers' Compensation Work Status Report
07-19-12: Subsequent Medical Report
07-19-12: Texas Workers' Compensation Work Status Report
07-27-12: Texas Workers' Compensation Work Status Report
08-10-12: Functional Capacity Assessment
08-13-12: Pre-Authorization Request
08-17-12: UR performed
08-23-12: Request for Consideration
08-30-12: UR performed
08-31-12: Subsequent Medical Report
08-31-12: Texas Workers' Compensation Work Status Report
09-28-12: Letter for reconsideration

PATIENT CLINICAL HISTORY [SUMMARY]:

Claimant is a female who reported a work-related injury that occurred on xx/xx/xx while working during her normal course and scope of employment. She reported her injuries to her employers and initially sought medical treatment with her primary care doctor who referred her to a neurologist. She was given hydrocodone 7.5/500 and Lyrica and recommended EMG/NCV of the upper extremities. The claimant underwent physical therapy two times and was evaluated who prescribed her Cymbalta 60 mg.

07-15-11: Visit Summary dictated. Diagnosis: Carpal Tunnel Syndrome. Treatment: Physical Therapy Ordered 3 times per week for 2 weeks, History and Exam. Work status: Return to work 7/15/11 with the following restrictions: specified to right and left hand/wrist: Lift/carry restrict: may not lift/carry objects more than 15 lbs for more than 8 hrs/day. Other: Limit repetitive wrist movements with both hands. Other: Begin physical therapy. Wear wrist splints when possible. History of present history: Claimant has noted pain and numbness in both hands at work for a year. Symptoms have progressively worsened. Pain now radiates proximally to both shoulders. Symptoms are now present constantly, but they worsen when she works. Location of pain: R/L 1st and 3rd fingers respectively. Modifying/Exacerbated factors: repetitive supination & pronation at work. Plain films taken. No NSAIDs due to history of both GERD and gastritis. Claimant given two ice packs. Provider comments: 19.20, secondary depression, tension headaches worse when hand pain is severe.

07-19-11: Initial Medical Report. The claimant reports ongoing right lateral wrist pain with numbness and tingling referred to her bilateral hands. Objective Clinical Findings: Examination of the left and right wrist reveals decreased ranges of motion. There is tenderness of the left and right wrist joint upon palpation. Phalen's test is positive bilaterally. There is decreased sensation of the left and right hand. There is weakness of the bilateral grip strength. Initial Diagnosis: Internal derangement of bilateral wrists. Treatment Plan: Refer for physical therapy; refer for an orthopedic consultation; Work status: The claimant is temporarily disabled; follow up her in two weeks.

08-03-11: Office Visit. Complaints of bilateral wrist pain referred to bilateral hands and referred to shoulders. Claimant stopped taking Lyrica due to rash. Objective: bilateral wrists: palpation: tender volar wrists; ROM: decreased ROM bilateral wrists; Ortho: positive Phalen's and Tinel's; Neuro: decreased sensation bilateral hands. Plan: continue Motrin and given Ultram 50mg PO BID. Follow up 4 wks. Device prescribed: electronic muscle stimulator, monthly supplies and accessories to use 3-4 times daily for 4 months, analgesic gel, conductive garment.

08-04-11: Daily Progress Note. Claimant reports ongoing pain to bilateral wrist. Objective findings/treatment intervention: There is tenderness and restricted range of motion of bilateral wrist. Weakness of bilateral grip strength. Treatment Protocol: therapeutic exercises, wrist protocol phase 1, neuromuscular re-education: finger wheel; manual therapy: joint mobilization and myofascial release to bilateral wrist; electric stim to bilateral wrist. Passive therapy: heat to the bilateral wrist. Assessment: The claimant's protocol was modified today. She started active care and demonstrated good ability for tendon glides. Plan of Treatment: continue current protocol: 3 days/week.

08-16-11: Consultation Note dictated. Complaint of bilateral wrist pain. Physical Examination: No significant restriction of motion left and right wrist. Grip strength is 5-/5 on the right, 5/5 on the left. Finkelstein test is positive mildly bilaterally. Tenderness dorsum fourth compartment right wrist. Tenderness dorsum first and

second compartment left wrist. Diagnosis: 1. Bilateral wrist sprain. 2. De Quervain's tenosynovitis, mild, bilateral. Treatment/Plan: 1. Physical therapy to normalize function bilateral wrists. Modalities indicated. 2. EMG done in April is pending, results not yet available for review.

08-22-11: Initial Plastic Surgery Consultation and Examination. Claimant complains of bilateral wrist pain. The pain/numbness occasionally wakes her up at night. She is currently taking narcotic pain medication that does not alleviate the pain at its worse. Physical Examination: Positive findings bilaterally in Phalen's test, Tinel's with percussion, Tingling/numbness. Assessment: 1. Bilateral upper extremity pain. 2. Late effect of crush injury. 3. B CTS. Treatment Plan: Needs further evaluation with EMG to assess the severity of the injury. Recommend bilateral steroid injections to her wrists in order to initiate conservative therapy protocol, as well as continuing to wear splints and NSAIDs.

09-07-11: Office Visit. Claimant rates her bilateral wrist pain 7/10. Claimant states she feels depressed. Physical therapy was denied. Objective: Palpation: tenderness to bilateral wrist joint upon palpation; ROM: Bilateral wrists are decreased; Ortho: positive Phalen's; Neuro: weakness of bilateral grip strength. Treatment Plan: FCE, QMHP specialist, Ultram 50mg PO BID, follow up in 4 weeks.

09-22-11: Work Capacity Evaluation. Occupational demands: Heavy PDL. Currently claimant is not working. She is currently performing at Light PDL, which indicates moderate functional deficit. The claimant was unable to complete the dynamic portion of this evaluation.

09-29-11: Designated Doctor Evaluation. Current medications: Tramadol, Lensoprazole. Work Status: The claimant reported she has not returned back to work since to injury, and is currently not working. Physical Examination: Upper extremity examination: Joint palpation of the upper extremities: Palpation of the bilateral upper extremities revealed tenderness to wrists. ROM of upper extremities: WNL. Return to Work Determination: Disability as a direct result of injury determination: the claimant's inability to perform the pre-injury employment from 4/26/11 to 7/18/11 is a direct result of the compensable injury.

11-30-11: Office Visit dictated. The claimant has continued pain with numbness, tingling and weakness bilateral hands. Physical Examination: Wrist compression test is positive. Mild tenderness to radial aspect both wrists. Finkelstein test positive bilaterally. Grip strength weakness. Diagnoses: 1. Bilateral wrist sprain. 2. De Quervain's tenosynovitis bilateral. 3. Carpal tunnel syndrome, bilateral. Treatment/Plan: Claimant informs that she has psychiatric evaluation scheduled, four visits.

12-13-11: IRO performed. Reason for denial: Based on the clinical information provided, the request for chronic pain management x80 hours is not recommended as medically necessary. The submitted records fail to establish that the employee has exhausted lower levels of care and is an appropriate

candidate for the tertiary level program. The submitted records note that the employee has undergone only two sessions of physical therapy to date. There is no documentation that the employee has undergone an adequate course of physical therapy, home exercise program or been treated with injection therapy. Given the current clinical data, the requested chronic pain management program is not indicated as medically necessary.

12-22-11: Subsequent Medical Report. Claimant complains of ongoing bilateral wrist pain. She states of more pain in the right wrist and reports bilateral wrist pain with greasing activities. Objective clinical findings: Examination of the left of left/right wrist reveals decreased ranges of motion, tenderness at bilateral wrist joints upon palpation, and positive Phalen's test bilaterally. There is decreased sensation to both hands and weakness of bilateral grip strengths. Treatment Plan: Pending CPM; Medications: Ultram 50 mg PO daily and Cymbalta 20 mg PO BID; Work status: the claimant is temporarily disabled; follow up in four weeks.

12-22-11: Work Capacity Evaluation. Occupational demands: Heavy PDL. Currently claimant is not working. She is currently performing at Light PDL, which indicates moderate functional deficit. The claimant was unable to complete the dynamic portion of this evaluation.

03-08-12: Subsequent Medical Report. Claimant complains of persistent bilateral wrist pain. She states of numbness and tingling of bilateral hand more on the right side. Objective clinical findings: Examination of the left of left/right wrist reveals decreased ranges of motion, tenderness at bilateral wrist joints upon palpation, and positive Phalen's test bilaterally. There is decreased sensation to both hands and weakness of bilateral grip strengths. Treatment Plan: Pending CPM; Medications: Ultram 50 mg PO daily and Cymbalta 60 mg PO BID; Work status: the claimant is temporarily disabled; follow up in four weeks.

03-08-12: Work Capacity Evaluation. Occupational demands: Heavy PDL. Currently claimant is not working. She is currently performing at Light PDL, which indicates moderate functional deficit. The claimant was unable to complete the dynamic portion of this evaluation.

04-23-11: Subsequent Medical Report. Claimant complains of persistent bilateral wrist pain more on the right side. She states of numbness and tingling of bilateral hand more on the right side. She states of increase in pain with daily activities. Objective clinical findings: Examination of the left of left/right wrist reveals decreased ranges of motion, tenderness at bilateral wrist joints upon palpation, and positive Phalen's test bilaterally. There is decreased sensation to both hands and weakness of bilateral grip strengths. Treatment Plan: Refer to FCE; claimant has designated doctor appointment on 7/6/12; Medications: Ultram 50 mg PO daily and Cymbalta 60 mg PO BID; Work status: the claimant is temporarily disabled; follow up in four weeks.

07-06-12: Designated Doctor Evaluation dictated. Claimant may return to work with restrictions. Current medications: Cymbalta and Tramadol. Claimant complains of consistent pain in nature that is increased with activities such as: reaching, sleeping, pushing, pulling, bending, cutting, and any repetitive movement. Hot packs, massage, rest and medication decrease pain. Current pain 6/10; at best 4/10 and at worst 10/10. Bilateral tenderness noted bilateral volar wrist. Bilateral wrists positive Phalen's test, negative Tinel's. Claimant complains of daily intermittent wrist and hand pain, numbness and weakness that occur with use of wrists, hands and fingers. The symptoms are worse on the 1st and 2nd and 3rd fingers. The claimant may return to work with restrictions. MMI was reached on 3/8/12, which is the last evaluation where it was noted that the claimant's condition had improved. The claimant noted that the combination of Cymbalta and Tramadol was controlling her pain. The claimant has an entrapment neuropathy. Given that her symptoms of neuropathy despite having normal range of motion and sensory exam, we will use table 16 on page 57 to determine the impairment. By history, her symptoms are mild and bilateral. Thus, she has a 10% upper extremity impairment on each side which converts to 6% on each side. Thus, when we combine 6% and 6%, the total Whole Person Impairment Rating is 12%.

07-19-12: Subsequent Medical Report. Claimant complains of persistent bilateral wrist pain more on the right side. She states of numbness and tingling of bilateral hand more on the right side. She states medications help manage pain. Objective clinical findings: Examination of the left of left/right wrist reveals decreased ranges of motion, tenderness at bilateral wrist joints upon palpation, and positive Phalen's test bilaterally. There is decreased sensation to both hands and weakness of bilateral grip strengths. Treatment Plan: Pending FCE on 7/24/12; Medications: Ultram 50 mg PO daily and Cymbalta 60 mg PO BID; Work status: the claimant is temporarily disabled; follow up in four weeks.

08-10-12: Functional Capacity Assessment. Occupational Demands vs. FCE Results: The claimant's occupational demand as a Warehouse Laborer requires a Heavy PDL. According to the results of evaluation the claimant is currently performing at a Sedentary-Light PDL, which indicates a moderate functional deficit. Recommendations: Analyzing the claimant's current clinical status, past medical history, and medical probability, a work conditioning program is indicated at this time. The program's protocol should concentrate on improving muscular and connective tissue flexibility, muscular strength and endurance, proper biomechanics, and functional performance by means of work simulation. At this time it does not appear to be any contraindications which prevent the claimant from participating in the program.

08-13-12: Pre-Authorization Request. Initial Findings: Pain level: at rest 4/10, activity 7/10; Functional Performance: Light-Medium; Biomechanics: poor coordination and fine motor skills of wrists and hands, limited bilateral upper extremity; Cardiovascular/Conditioning: fair, moderate fatigue; Strength: limited grip strength, weakness and fatigue of upper extremities with activity; ADL's: limited with increased bilateral wrist pain while performing activities that require

grasping, lifting, and movement of bilateral wrist. Treatment Plan: Work conditioning individualized protocol concentrating on improving muscular and connective tissue flexibility, muscular strength and endurance, body mechanics, cardiovascular conditioning, and functional performance by means of work stimulation. Goals: improve functional performance levels; improve strength and endurance levels; reduce pain levels during and after activity; improve neuromuscular control of the upper extremities; promote proper biomechanics; motivate claimant on being less focused on pain; motivate claimant towards returning to work; achieve MMI. Specific Request: Individualized work conditioning program, consisting of 80 hrs, addressing issues which are presently preventing the claimant from achieving the target physical demand level, thus allowing her to return to gainful employment. A subsequent Functional Capacity Evaluation will be performed to monitor claimant's progress.

08-17-12: UR. Reason for denial: In absence of a specific event and given that the only testing done has been x-ray and EMG, both of which were negative; I do not feel that all appropriate diagnostics have been performed as required by ODG for admission into a CPMP. Further evaluation with a definitive diagnosis may indicate the need for additional treatment prior to this type of treatment. I cannot, therefore, support a CPMP at this time or until a definitive diagnosis is established and appropriate treatments exhausted. Recommend denial.

08-30-12: UR. Reason for denial: This is an overuse injury to the bilateral wrists with a working orthopedic diagnosis of carpal tunnel syndrome (CTS). De Quervain's and wrist pain. The claimant has had no injections or surgery. She has had minimal therapy and does not appear to have attempted return to work. Chronic Pain Management Program was denied 12/31/11 Independent Review level due to failure to complete lesser levels of care. The current request is for Work Conditioning (not work hardening as documented). There has been no change in medical status. At this time, the ODG does not support physical therapy for CTS and wrist pain. There is clearly some functional overlay with the patient which will not be likely to respond to any therapy which does not include a psychological component. Work Conditioning/Work Hardening is not supported in this case. Request denied.

08-31-12: Subsequent Medical Report. Claimant complains of persistent bilateral wrist pain. She states of numbness and tingling of bilateral hand more on the right side. She states of pain when trying to put lotion on her body and even when trying to cut vegetables. Objective clinical findings: Examination of the left of left/right wrist reveals decreased ranges of motion, tenderness at bilateral wrist joints upon palpation, and positive Phalen's test bilaterally. There is decreased sensation to both hands and weakness of bilateral grip strengths. Treatment Plan: Pending IRO for WCP; Medications: Ultram 50 mg PO daily and Cymbalta 60 mg PO BID; Work status: the claimant is temporarily disabled; follow up in four weeks.

09-28-12: Letter for reconsideration. 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 conditioning program. Medical probability indicates that the claimant has a great potential to benefit from the work conditioning program and the requested 80 hours of work conditioning will allow us to return her to unrestricted work duty and achieve case resolution.

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

Denial of 80 hrs of work conditioning is upheld/agreed upon since per ODG Pain Chapter, request exceeds recommended 30 hrs over 4 weeks. And clinically there is no specific notation of lower levels of care in regards to number of PT visits and their benefit. And there are psychosocial barriers to recovery in that there is a large gap between current Sedentary-Light abilities versus Heavy job demands – a chasm difficult to bridge with just 30 hours of work conditioning is not the appropriate level of rehabilitation at this point. Also, there is evidence of psychosocial barriers to recovery given opioid medication and psychotropic medication use. Also, there is question of plan (goal of return to function/productivity given off work since the injury – 18 months ago). Therefore, after review of the medical records and documentation provided, the request for 97545 Work Conditioning x80 Hours, 97546 Work Conditioning Add-On, is not medically necessary and is denied.

Per ODG:

<p>Work conditioning, work hardening</p>	<p>Criteria for admission to a Work Hardening (WH) Program:</p> <p>(1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation:</i> 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.</p> <p>(3) <i>Job demands:</i> 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).</p>
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- (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)**