

# CASEREVIEW

**8017 Sitka Street  
Fort Worth, TX 76137  
Phone: 817-226-6328  
Fax: 817-612-6558**

Notice of Independent Review Decision

**[Date notice sent to all parties]:** September 20, 2012

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work Hardening 80 hours 97545 97546 Multiple Body Parts

**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 injured on XX/XX/XX. She was with kids and when the music stopped a child ran up to give her a hug, causing her to lose her balance and fall with the child on top of her. She sustained injuries to her head, low back, left shoulder and neck. Her main complaint has been her lower back. On September 13, 2011, Dr. performed a lumbar fusion. On May 25, 2012, she

sought out Dr. for a second opinion. She continues to have left-sided radicular symptoms with left-sided lower extremity pain, numbness, tingling, and weakness. Records indicate that she is currently on disability.

On July 19, 2011, Operative Report by, MD. Postoperative Diagnosis: 1. Left C3-4 facet syndrome. 2. Left C4-5 facet syndrome. 3. Right C3-4 facet syndrome. 4. Right C4-5 facet syndrome. Procedures: 1. Left C3-4 facet rhizotomy. 2. Left C4-5 facet rhizotomy. 3. Right C3-4 facet rhizotomy. 4. Right C4-5 facet rhizotomy.

On November 11, 2011, the claimant was evaluated by, LPC at the request of her treating doctor, DO CO, to assess her emotional status and to determine the relationship to the work accident. She scored a 23 on the BDI-II indicating moderate depression. Her score on the BAI was 15, reflecting mild anxiety. Her responses on the Fear Avoidance Beliefs Questionnaire (FABQ) showed significant fear avoidance of work (FABQ-W = 38) as well as significant fear avoidance of physical activity in general (FABQ-PA = 24). Multiaxial Diagnosis: Axis I: Pain Disorder Associated with both Psychological Factors and a General medical Condition. Bipolar disorder. Axis II: Diagnosis deferred. Axis III: Injury to head, neck, low back, right shoulder and right hip. Axis IV: Primary Support Group, Social Environment, Economic, and Occupational Problems. Axis V: GAF=45 (current) Estimated pre-injury GAF=85. Assessment: It was determined that the work accident pain and ensuing functional limitations had caused the patient's disruption in lifestyle, leading to poor coping and maladjustment and disturbances in sleep and mood. It was recommended she receive immediate authorization for participation in four sessions of individual psychotherapy.

On June 16, 2012, CT Lumbar Myelogram, Impression: 1. Status post remote discectomy, anterior interbody fusion and bilateral pedicle screw fixation at L4-L5. However, there is no solid bone effusion seen at this segment. 2. Grade I spondylolisthesis at L4-5. 3. Mild degenerative spondylosis at L1-L2 and L3-L4. 4. Mild degenerative facet joint hypertrophy from L3-L4 through L5-S1.

On July 18, 2012, the claimant was evaluated by MD who reported she continued to have left-sided radicular symptoms with left-sided lower extremity pain numbness tingling and weakness. Current medications: Lyrica 100 mg, Valium 5 mg, Seroquel 300 mg, Hydrocodone-acetaminophen 10-325 mg, and Skelaxin 800 mg (It is reported that she receives psychotropic medication management through the Guidance Center regarding Valium and Seroquel). On physical examination the cervical motion was within normal limits without appreciable tenderness. Her upper extremity motor strength, sensation, and reflexes were within normal limits. Her lumbar spine range of motion was reduced with flexion, limited to about 60 degrees, extension 10 degrees, and right and left flexion 10 degrees. Lower extremity strength was 5/5 bilaterally. Her knee jerk reflexes were mute bilaterally. Ankle jerk mute. Her gait was slightly ataxic. Impression: Lumbar disc disease status post L4-5 fusion continuing to heal. Plan: Work Hardening Program.

On July 18, 2012, the claimant underwent a Physical Performance Evaluation.

Occupation at the time of injury: From 5/5/10 through present the claimant had taken a leave of work due to the work injury. Results: She could not completely perform in the 20 to 50 pound medium lifting category on an occasional basis on the PILE lifting protocol. Therefore, she was listed in the medium lifting category and should be restricted to no more than 25 pounds of dynamic lifting on an occasional basis and 15 pounds on a frequent basis. It was opined that the claimant was unable to safely perform her job demands based on comparative analysis between her required job demands and her current evaluation outcomes.

On July 25, 2012, the claimant underwent an Assessment/Evaluation for Work Hardening Program at xx. Mental Status: She ambulated slowly with slight antalgic gait and frequently shifted in the chair. Her affect was slightly constricted, but appropriate to the content of the assessment, while her mood euthymic and she was able to express appropriate frustration during the session. Multiaxial Diagnosis: Axis I: Pain Disorder associated with both psychological factors and a general medical condition, chronic. Bipolar Disorder. Axis II: Diagnosis Deferred. Axis III: Injury to head, neck, low back, right shoulder, and right hip. Axis IV: Primary support group, social environment, economic, and occupational problems. Axis V: GAF=63 (current) Estimated pre-injury GAF=85. Vocational Status/Plan: The claimant was terminated on XX/XX/XX (24 years totaled with the company). She has an Associate's Degree in. The claimant was reported to be eager to return to the work force. She is considering returning to work in a different position and different employer. She is considering returning as a for the elderly or the handicapped. Recommendation: Work Hardening Program.

On August 1, 2012, a work hardening program pre-authorization request indicated that the claimant had worked 22 years prior to the work injury. Since her injury she received x-rays, MRI, EMG, CT scan, Myelogram, Discogram, physical therapy, injections, some return to work program care, but it is undetermined what program or duration of care. She had completed 8 individual psychotherapy sessions. It was also reported that the claimant voiced much pain as a result of back surgery on 9/13/11, especially in her left leg, which hurts her from mid-back to her foot. It was also noted she completed post-op physical therapy. A work hardening program was recommended by her treating physician due to the claimant's persistent functional deficits, which were impeding her ability to make a safe return to work. A comparative analysis of the claimant's symptoms prior to treatment and those given currently was provided. Overall, she had greater than 60% reduction; except for pain and DBI-II (Depression) which she only had 43% in reduction. It was reported that individual psychotherapy had exerted some positive impact on her symptoms; however, she continues to demonstrate some psychological overlay. With the psychological overlay, the claimant was noted to require a program with a group psychotherapeutic component, such as the one offered in the Work Hardening Program. The Functional Capacity Evaluation performed on 07/18/12 was reported to reveal the claimant was functioning at a MEDIUM [15-25lbs]. PDL and the job requires a MEDIUM [20-50-lbs]. It was opined that the claimant had shown modest improvement with outpatient physical therapy modalities and they were now recommending progression to a Work Hardening Program for progress to continue to be achieved.

On August 6, 2012, MD performed a UR. Rational for Denial: Based on the clinical documentation provided for review the patient underwent a prior low back surgery in 09/11 and has continued to demonstrate loss of function and pain despite multiple post-operative interventions. It is unclear from the clinical documentation to what extent the patient attended physical therapy and there are no physical therapy evaluation reports demonstrating a plateau with rehabilitation. The clinical documentation provided for review does not contain a return to work agreement with the patient's employer and no significant functional limitation were noted on physical examination that would reasonably require an 80 hour work hardening program. The most recent physical performance evaluation demonstrated that the claimant was able to perform her job functions. Given the lack of clinical documentation regarding functional deficits, prior conservative treatment, and a return to work agreement; medical necessity is not established.

On August 30, 2012, MD performed a UR. Rationale for Denial: According to the 8/15/12 report, individual psychotherapy has been beneficial, specifically in terms of reduction of pain, irritability, frustration, tension, anxiety, depression, sleep disturbance, and forgetfulness. However, the patient continues to demonstrate psychological symptoms that would require a program with a group psychotherapeutic component. The previous request was non-certified because extent of physical therapy and plateau of response were not clearly demonstrated, a return to work agreement with the patient's employer was not provided, and significant functional limitations were noted on physical examination. Updated documentation submitted for this appeal still did not address the aforementioned concerns. There was no mention of the total number of regular physical therapy visits attended to date to indicate that the patient has already completed an adequate duration of PT. Likewise, leveling of response to therapy modalities was still not objectively documented. Additionally, a return to work agreement with the patient's employer was still not provided. In fact, it was reported in the records that the patient's previous occupation is currently unavailable. Moreover, the latest PPE indicated that the patient is functioning at Medium PDL, while cited job demands require Medium PDL. Although it was mentioned that the patient still had functional deficits that prevent her from safely returning to work, there was no indication that these cannot be addressed by regular PT or a structured home program to warrant a multidisciplinary rehabilitation program at this point. Furthermore, while the patient is noted to have residual psychological symptoms, it is not clear why these would have to be addressed by a multidisciplinary program. Notably, the patient has responded well to individual psychotherapy.

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

Denial of 80 hrs of work hardening is upheld/agreed upon. Per ODG Pain Chapter criteria, submitted information does not document loss of function. Physical testing notes Medium physical level commensurate with demand level claimant is considering as a sitter since claimant is not returning to job of injury. There is also no submitted information regarding extent of or progress with previous levels of rehabilitation. And there is no submitted information regarding

medication management as potential barrier to recovery given recent history of narcotic pain analgesics and psychotropic medication. Therefore, the request for Work Hardening 80 hours 97545 97546 Multiple Body Parts is denied as it does not meet ODG criteria.

**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 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)**