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Notice of Independent Review Decision

Date notice sent to all parties:
August 27, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Request/Appeal for Work Hardening Program x 80 hours Not Medically Certified by Physician Advisor/Appeal Upheld.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Texas Licensed Psychologist

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

☐ **X** 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:
Initial behavioral medicine consultation dated 06/20/2012 signed by, LPC/Dr.; work hardening history and physical dated 06/20/2012 signed by Dr.; Functional Capacity Evaluation dated 06/20/2012 signed by Dr.; Designated Doctor Evaluation dated 06/22/2012 signed by Dr.; clinical note dated 06/25/2012 signed by Dr.; work hardening program pre-authorization request dated 06/26/2012, Functional Capacity Evaluation dated 07/05/2012 signed by OTR; work hardening program preauthorization request dated 07/12/2012 signed by, PSYD, LPC; and working documents.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male who reported injury on xx/xx/xx. Initial behavioral medicine consultation dated 06/20/2012 indicated the patient presented for behavioral medicine consultation to determine his suitability for some level of behavioral medicine treatment and/or a return to work program. The patient reported he was lifting heavy boxes and immediately experienced severe pain in his right groin. The patient reported he continued to work his shift, and at night his wife drove him to Center. He was examined and completed an ultrasound, which confirmed a hernia. He received ibuprofen, medication, and was placed on light duty restriction. The patient currently reported utilizing ibuprofen over-the-counter tablets as needed. The

patient had complaints of pain rated at 5/10 on the VAS without medications and with medications he rated his pain at 2/10. The pain was described as aching at the site of the surgery incision. The patient also described an aching pain in the front, lower quadrant of his abdomen bilaterally. However, he reported increased sensitivity on his right side. He reported pain was worsened with repetitious movements, lifting, climbing the ladder, bending, carrying, pushing, and pulling. The patient reported difficulties performing household chores and yard work, cooking, driving, sitting for more than 45 minutes, standing for more than 30 minutes, walking for more than 45 minutes, bending, squatting, climbing stairs, lifting/carrying objects, and engaging in sexual activity. He reported difficulty picking up his son. The patient reported feeling useless, helpless, like a burden, disappointed, and angry. He reported both initial and sleep-maintenance insomnia. His mood was slightly anxious, while his affect was appropriate to content. He scored a 7 on the Beck Depression Inventory, indicating minimal depression, and an 8 on the Beck Anxiety Inventory, indicating mild anxiety. The patient was recommended to undergo a work hardening program. Work hardening history and physical dated 06/20/2012 indicated the patient presented with complaints of bilateral inguinal hernias and a ventral hernia. The patient had surgery on 04/19/2012 and was doing well postoperatively; however, he continued to have pain in the area of the surgeries with some generalized pain and tenderness in his abdomen. He felt unable to lift any weight. There was some mild generalized abdominal tenderness with no focal tenderness. The patient was recommended to begin a work hardening program. Functional Capacity Evaluation dated 06/20/2012 indicated the patient was currently unable to perform his job demands. He was recommended to begin work hardening. Designed Doctor Evaluation dated 06/22/2012 indicated the patient presented for evaluation. On physical examination, the scrotum revealed normal testis downgoing with no pain and no tenderness noted in the scrotum. There was no pain or tenderness in the inguinal examination, and there were no recurrent pulsations or hernias felt on examination. The incisions were well healed, and the patient was doing extremely well. The patient was noted to have reached maximum medical improvement. The patient was given an impairment rating of 0% whole person. The addendum for Functional Capacity Evaluation additional testing dated 07/06/2012 indicated the Functional Capacity Evaluation documented the patient to perform at a medium PDL, and his job occupation required a heavy PDL. As a result, the patient was mildly deconditioned and was unable to return to his own occupation without additional conditioning. However, the patient was noted to be able to return to work performing at a medium PDL. Work hardening program preauthorization request dated 06/26/2012 indicated the patient scored a 7 on the Beck Depression Inventory, indicating minimal depression, and an 8 on the Beck Anxiety Inventory, indicating mild anxiety. The note indicated that the patient underwent a Functional Capacity Evaluation on 05/22/2012, which revealed the patient was functioning at a heavy PDL, and the job required a heavy PDL. The note indicated the patient showed modest improvement with outpatient physical therapy modalities, and the patient was being recommended to undergo a work hardening program. Functional Capacity Evaluation dated 07/05/2012 indicated the patient qualified for the work category of medium PDL. The note indicated the patient’s effort and consistency were rated as good. Reconsideration for work hardening program preauthorization

request dated 07/12/2012 indicated the patient reported his employer was unable to accommodate light duty restrictions and has been off work since the date of injury. The note indicated the Functional Capacity Evaluation performed on 05/22/2012 revealed the patient do be functioning at a heavy (50 to 70 pounds) PDL, and the job required a heavy (50 to 100 pounds) PDL.

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

The clinical documentation submitted for review does not support the requested 80 hours of work hardening. Official Disability Guidelines state work hardening may be recommended as an option, depending on the availability of quality programs. This request was denied on 07/05/2012 by Dr., as the patient was noted to have reached maximum medical improvement on 06/25/2012 per the independent medical examination. Additionally, the determination indicated that the submitted records failed to establish that the patient had undergone an adequate trial of physical therapy with improvement followed by a plateau. The request was again denied on 07/15/2012 by Dr., explaining that the patient had not attempted to return to work because he was released with restriction and his employer did not accommodate for restrictions. However, the determination indicated the argument was not supported by the provided documentation. The IME indicated that the patient reached maximum medical improvement as of 06/25/2012, which indicated the patient could resume his normal activities. There was still insufficient documentation submitted to indicate the need of a work hardening program at this time. Although the documentation indicated the patient had completed a course of physical therapy, it is unclear based on the documentation when the patient underwent physical therapy and for how many sessions. It is unclear that the patient demonstrated significant improvement followed by a plateau. Additionally, the documentation indicated the Functional Capacity Evaluation dated 05/22/2012 revealed the patient was functioning at a heavy PDL, and the job required a heavy PDL. Given the above information, the request for 80 hours of work hardening cannot be substantiated at this time.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☐ **X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Guidelines Reference Used:

Official Disability Guidelines, Pain Chapter, Online Edition.

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.