

Medical Assessments, Inc.

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Notice of Independent Review Decision

October 10, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Work Hardening x 10 Sessions

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

The Reviewer is a Chiropractor with over 13 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:

07/02/2013: Functional Capacity Evaluation
07/22/2013: Pre-Authorization Request
07/25/2013: UR performed
07/31/2013: Work Hardening Assessment
08/16/2013: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male, on xx/xx/xx sustained injuries to his neck, back, shoulders and right wrist. The claimant had 12 sessions of PT. The request is for 10 sessions of work hardening. It was recorded in the records that the claimant underwent a Lumbar X-Ray Study on 2/20/2013 which revealed: 1. Mobile retrolistheses L2-L3 with fixed retrolisthesis at L4-L5. On March 14, 2103, MRI of the Lumbar revealed: 1. Anatomical alignment of the lumbar spine is seen in the neutral as well as flexion and extension position. 2. No segmental instability,

occult fracture of spondylolysis is noted. 3. At L4-L5 an annular disc bulge flattens the thecal sac. 4. At the L5-S1 level in the neutral and extension position, a focal 5.0 mm subligamentous disc extrusion is seen without nerve root compression. Mild bilateral foraminal narrowing is present. With flexion resolution of the focal disc extrusion is identified. MRI Cervical Spine Impression on June 14, 2013 revealed, 1. Disc herniation measuring 3.1 mm at C3-C4, 3.6 mm at C4-C5, and 4.5 mm at C5-C6 without spinal stenosis. 2. Unconvergent hypertrophy with minimal neural foraminal narrowing on the left at C2-C3.

07/02/2013: Functional Capacity Evaluation. Chief Complaints: Claimant reported continued neck, mid back, lower back, bilateral shoulders, right wrist and chest pain. Medications: Claimant stated that he was taking prescribed medications to control his pain levels, but could not recall the names. Sensation Testing: Sensation to pinprick and light touch were noted to be within normal limits over the patient upper and lower extremities. Reflexes were 2/5. Strength Testing of the upper and lower extremities was 5/5. Orthopedic Examination: Cervical Distraction test was positive for an increase in posterior cervical myalgia. Maximum foraminal compression testing was positive bilaterally for an increase in posterior cervical myalgia. Shoulder depression testing was positive bilaterally for an increase in posterior cervical myalgia. O'Donoghue's was performed revealing muscular strain and ligamentous sprain along the posterior cervical soft tissues. No radicular symptoms were elicited while performing the above orthopedic exams. Valsalva was negative. Straight leg raise was performed noting induction of lower back pain with 60 degrees of right hip flexion and with 60 degrees of left hip flexion. Lasegue's did not induce neurological symptoms. Kemps reproduced the patient's symptomatology, which indicates disruption of the lumbar joints. Yeoman's and Hibb's were performed revealing intact SI joints bilaterally. O'Donoghue's revealed muscular strains and ligamentous sprains. Moderate myalgia was elicited during these exams. Apley's scratch was bilaterally performed revealing anatomical motion with end range of motion pain. Anterior and posterior shoulder glide revealed stable shoulder girdles bilaterally. Active range of motion was noted to be anatomical with induction of end range of motion pain. Ncer's and supraspinatus press were noted as being positive for induction for myalgia bilaterally. Passive motion of the right carpal bones induced moderate levels of pain in the medial aspect of the right wrist. The right wrist medial and lateral collateral ligaments were stress tested noting intact ligamentous structures. Resisted Supination and Pronation was performed and noted to be within normal limits. Mills and Cozen's tests were performed and noted as being positive for right lateral epicondylitis. Golfer's elbow test was performed and noted as being positive for medial epicondylitis. The intrinsic muscles of the right hand were noted at a 5/5 when stress tested. Patient verbally expressed having an increased level of pain in the right hand while stress testing the intrinsic muscles. Bunel-littlers test was performed noting anatomical capsular structures. Palpation: Muscular examination reveals hypertonicity and tenderness in the left trapezius, left suboccipital, left levator scapula, left cervical paraspinal, right trapezius, right suboccipital, right levator scapula, right cervical paraspinal, left rhomboids, left thoracic paraspinal, right rhomboids, right thoracic paraspinal, right wrist flexors, right wrist extensors, left lumbar paraspinal, left quadratus

lumborum, right lumbar paraspinal, and right quadratus lumborum muscle. Palpation reveals tenderness in the left deltoid, left teres minor, left supraspinatus, left infraspinatus, right deltoid, right teres minor, and right infraspinatus muscles. Diagnosis: 1. Displacement IVD, Lumbar, 2. Post Traumatic Headache, 3. Sprain/strain Cervical, 4. Sprain/Strain Lumbar, 5. Sprain/strain Right Wrist, 6. Sprain/strain Bilateral Shoulder, 7. Costochondritis., 8. Myalgia.

FCE Notations: Lifting exercise: Patient was able to complete the box lifts with 27 pounds of resistance; unfortunately, the patient remarked of increased radiating lower back pain. Patient was able to complete the lifting exercises denoting poor, unsafe biomechanics with early cardiovascular fatigue as he attempted to guard his lower back region. Squat and reach: Patient was able to complete, but remarked of severe radiating lower back pain with early signs of cardiovascular fatigue. Patient was given ample time to recover between sets. Leg kicks: Patient was able to complete inducing mild-moderate thoracic pain and stiffness. Squat: Patient attempted and completed the squat exercise denoting a severe increase in radiating lower back pain. Patient denoted poor biomechanics with induction of early fatigue. Patient was given a prolonged break post completion to allow for reduction of lower back pain. Back lift: Mr. completed the examination, but remarked that every repetition completed induced a severe stabbing sensation between his shoulder blades. Patient refused to stop the exercise stating that he could work through the pain. Patient's functional biomechanics were noted to progressively worsening as he attempted to complete the back lift portion of the examination. Stair Climb: Patient complete but required the use of the handrails throughout the examination denoting a server induction of radiating lumbar pain, which the patient feared would cause him to fall. Patient demonstrated antalgic posturing throughout with induction of early fatigue. Balance: Patient was unable to complete without induction of clinical symptomatology. Stooping: Patient was able to complete denoting poor biomechanics, early fatigue with a severe induction of radiating lower back pain. Patient was asked if he wanted to refrain from the activity, but said he would like to complete the exercise and only asked for prolonged breaks between repetitions to regain his composure. Kneeling: Patient was able to place his body weight onto his flexed knees, but complains of an increase in sharp, radiating lumbar pain. Crawling: Patient completed but complained a significant increase in radiating lumbar pain, which he described as pins and needles encompassing his compensable regions.

Assessment: the patient's subjective complains are consistent with the objective findings. The patient demonstrates that he cannot perform some of his regular activities for prolonged periods of time without an increase in severe radiating lumbar pain. The Patient also demonstrates loss of range of motion, rigidity, weakness, poor body mechanics and fear avoidance behavior. There was no current evidence of secondary gain by the patient. The patient demonstrated clinically significant biomechanical issues and induction of pain that could recommendation that he remain on a restrictive basis until these functional ailments are corrected. Based on clinical presentation, history of injury and medical algorithm completed to this point, it is currently within all reasonable

medical probability to presume that the patient's pain, rigidity, cardiovascular deficits and anxieties are all significant factors in preventing the patients from achieving clinical MMI; therefore, it is currently within all reasonable medical probability to presume that his subjective and clinical symptomatology will significantly benefit from a Work Hardening Program.

07/25/2013: UR performed. Rationale for Denial: The claimant is xx month status post injury. The FCE stated his job requires a light level and demonstrated the ability to lift 27 pounds at a frequent rate, placing him at the Medium physical demand level. There is no behavioral assessment submitted that reveals any psychosocial overlay. The FCE suggested fear avoidance; however the claimant performed all the tasks on the evaluation with no problem or fear avoidance. The request is not in keeping with ODG guidelines for work hardening that state under #3 that job demands should be Medium or higher. Given the FCE report, the claimant should be able to return to full and unrestricted job duties and continue with a self-directed home exercise program. Recommend nonapproval of 10 sessions of work hardening.

07/31/2013: Work Hardening Assessment, Presenting Problem: Claimant reports continued neck, mid back, lower back, bilateral shoulders, right wrist and chest pain. Therapist assessment: the patient would benefit from attending a work rehabilitation program, which will emphasize increasing strength, teach proper body mechanics, cardiovascular conditioning, sound ergonomic principles and group therapy. He will participate in group therapy 1 time a week where he will be able to process with group support and group dynamics the effects of the injury on his personal and work life. He is motivated to rehabilitation and return to work. These suggestions will teach him to work within his pain tolerance level, decrease the chance of re-injury and help him transition back to the work force.

08/16/2013: UR performed. Rationale for Denial: Based on the clinical information provided, the appeal request for work hardening X 10 sessions is not recommended as medically necessary. Initial request was non-certified noting that the functional capacity evaluation states the patient's job requires a light level and he demonstrated the ability to lift 27 pounds at a frequent rate, placing him at the medium physical demand level. The request is not in keeping with ODG guidelines for work hardening that state under #3 that job demands should be medium or higher. Given the functional capacity evaluation report, the claimant should be able to return to full and unrestricted job duties and continue with a self-directed home exercise program. There is insufficient information to support a change in determination, and the previous non-certification is upheld. The patient is capable of working at his required PDI, which is only a light PFL and fails to meet ODG criteria for admission to a work hardening program. Peer to peer discussion was unsuccessful.

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

After reviewing the medical records, the appeal submitted requesting work hardening X 10 sessions is not medically necessary. Job duties that are submitted are categorized as of light level job demand. The FCE revealed performance was achieved at a medium job level demand. Based on the ODG guidelines, work hardening criteria # 3 Job demands, no clinical findings support the medical evidence for work hardening. No documentation supports the medical necessity of work hardening as described by the ODG criteria, therefore the claimant should be able to return to full and unrestricted job duties, and continue with a self-administered home exercise program. The request for work hardening x 10 sessions is denied.

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](#)). Exceptions to the 2-year post-injury cap may be made for patients with injuries that have required long-term medical care; i.e., extensive burns, diagnoses requiring multiple surgical procedures, or recent (within 6 months) completion of the last surgery, for patients who do not have the psychological barriers to return to work that would qualify them for a CPM program. ([L&I, 2013](#))
- (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)**