Specialty Independent Review Organization

Notice of Independent Review Decision

Date notice sent to all parties: 1/4/2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
The item in dispute is the prospective medical necessity of 80 hours of work hardening.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation.

REVIEW OUTCOME:

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

☒ Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer agrees with the previous adverse determination regarding the prospective medical necessity of 80 hours of work hardening.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
Records were received and reviewed from the following parties:

These records consist of the following (duplicate records are only listed from one source): Records reviewed:
IRO Request Form – 12/17/12
DWC1 – 11/15/11

Adverse Determination Letters – 11/9/12 & 12/6/12
Pre-authorization Determination Letters – 1/13/12, 3/16/12, 4/16/12, 6/15/12, 10/15/12

Pre-authorization Request – 12/10/12

Work Hardening Program Pre-Authorization Request – 11/5/12
Reconsideration Work Hardening Program Pre-Auth Request – 11/19/12
LHL009 – 12/10/12
DWC69 – 8/9/12

MMI Report – 8/9/12

Records reviewed

Patient Face Sheet – undated
Evaluate & Treat Script – 9/14/12
Patient Report of Work Duties – 10/16/12
Contact with Employer – 10/16/12-10/17/12
FCE – 9/28/12
Multidisciplinary Work Hardening Plan & Goals of Treatment – 10/16/12
Initial Behavioral Medicine Consultation – 9/27/12
Assessment of Work Hardening Program – 10/17/12

Job Description – 10/17/12

History and Physical Report – 10/31/12

Records reviewed

Pre-auth request – 11/5/12

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:
The injured employee was injured on the job on xx/xx/xx while employed. She slipped in a puddle of water and slid forward, twisting her leg sideways and doing a partial split. The compensable injured body parts are the right knee and the lower back. The worker received primary care including injection to the right knee. She went to surgery in March 2012 for right knee arthroscopic partial medial meniscectomy. She received postoperative physical therapy.

On August 9, 2012 a Designated Doctor found the worker to be at MMI effective 05/30/2012, with a permanent impairment rating of 6% for lumbar spine DRE category II and for specific disorder category pertaining to the knee surgery. On the day of the Designated Doctor examination the worker reported feelings of depression, anxiety, emotional disorders as a result of the injury.

On 09/27/2012 an initial Behavioral Medicine Consultation was done, wherein the examiner recommended a psychotropic medication consultation and four sessions of psychotherapy. The psychotherapy sessions were completed. The

records submitted for this review contain no further reference to a psychotropic medication consultation.

A functional capacity evaluation was performed 09/28/2012. The worker performed at a light medium PDL, whereas the worker's own description of her job activities fell within the medium level. She specifically wrote that she lifted/carried weights of 30 to 50 pounds twice a day. According to an interview 10/16/2012 with a representative the job title involves occasional lifting of 25 pounds, no more. According to the person interviewed the worker's job requirements are in the light-medium category, involving weight lifting of 21-30 pounds. No information was obtained regarding return to work options. On 10/17/2012 a three page fax message listed the duties and requirements for the job title. Included in the fax transmission was a handwritten remark that Employees "should not have to lift anything over 25 lbs. The are heavier but they are not supposed to lift these without help. I am trying to get a job description from the campus where (___) worked last for the specific duties she had. Preauthorization for a work hardening program (WHP) was requested 11/05/2012. In the request, reference was made to findings and recommendations from the Behavioral Medicine Consultation Initial Clinical Interview (including the BDI score 34 and the BAI score of 20) in order to justify the need for a work hardening program which would include a group psychotherapeutic component. However, the specific recommendation for psychotropic medication consultation did not appear in the pre-certification request or in the proposed plan of treatment for the Work Hardening Program.

The requested WHP was non-authorized 11/09/2012.

On 11/19/2012 a request was made for reconsideration for the work hardening program. Again, reference was made to the light medium physical performance level on the FCE and also to fear avoidance beliefs about work and fear avoidance beliefs about physical activity.

On 12/06/2012 the adverse determination was upheld after reconsideration.

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

In accordance with the ODG Integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic) (updated 12/28/12), pertaining to Work conditioning, work hardening, Criteria for admission to a Work Hardening (WH) Program, the following criterion for enrollment has not yet been met:

(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.

As mentioned in criterion (18) 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". In the request for preauthorization of the proposed WHP, specific reference was made to findings and recommendations from the Behavioral Medicine Consultation Initial Clinical Interview in order to justify the need for a work hardening program, which would include a group psychotherapeutic component. However, the Behavioral Medicine Consultation of 09/27/2012 included on the third page of the four page document a specific recommendation for a psychotropic medication consultation in addition to four sessions of individual psychotherapy. Although the records confirm that psychotherapy sessions were completed, there is no mention in the reviewed records that the psychotropic medication consultation was requested or obtained.

ODG Integrated Treatment/Disability Duration Guidelines, Knee & Leg (Acute & Chronic) (updated 12/28/12), 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.

The patient does not meet the entire criterion from the ODG; therefore, the requested service is not medically necessary.

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)**