

# AccuReview

An Independent Review Organization

569 TM West Parkway

West, TX 76691

Phone (254) 640-1738

Fax (888) 492-8305

Notice of Independent Review Decision

**[Date notice sent to all parties]:** June 25, 2013

**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 in Physical Medicine and Rehabilitation with over 22 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 male that was injured while at work on xx/xx/xx and complains of back pain. He stated that he dropped his measuring tape and when coming up hit the corner of the scissor lift with his back.

10-31-12: Office Visit dictated by DO. The claimant was seen immediately due to the emergent nature of the injury. He suffered a direct blow. PE: Musculoskeletal: Lumbar: An abrasion of the midline L-spine, full ROM with pain, erythema of the midline L-spine, spasm of the paraspinal muscles, and tenderness of the paraspinal muscles. X-ray was negative. Assessment: 1. Contusion of the lumbar region, 922.31, 2. Abrasion back, 911.0. Plan: OTC NSAID, icy hot patches to avoid abrasion, modified duty, re-check in one week.

11-07-12: Visit Notes dictated by PT. Lumbar Evaluation: Subjective: low back pain. Essential Job Functions: lifting, climbing, carrying; Job title: electrician. Claimant reported his pain at 9/10 and aggravated by movement and sleep postures. Objective: Integumentary: a healing abrasion at midline in the low lumbar area is noted. AROM: Lumbar Spine: flexion 25 deg; extension: neutral; right lateral flexion: 10 deg; left lateral flexion: 10 deg. Palpation: tender over the low lumbar area at midline and over the PS in that same area. Transitional movements/mobility: mod difficulty with transitional movements including sit to supine, supine to sit, and prone to supine. Assessment: Claimant good candidate for PT. Functional Restrictions include: difficulty with lifting, bending, and stooping. Goals: within 3-5 visits: 1. Increase ROM and MMT to WNLs, 2. Decrease pain by 70%, 3. Pt independent in HEP, 4. Increase functional status to demonstrate ability for full duty RTW, including. Plan: PT daily x2 daily with therapeutic exercises and therapeutic activities combined with CP to progress towards goals. Therapeutic exercises such as stretching, strengthening, stabilization, aerobic conditioning to address the impairments of ROM, muscle performance, postural stability, and aerobic capacity. This may include education to address posture, body mechanics and home program. Therapeutic activities to include lifting, pushing, pulling, carrying, climbing to address the ability to perform the identified essential job functions. Heat/cold to address localized pain and inflammation.

11-07-12: Progress Note dictated by DO. Claimant presented with low back pain. He stated that he cannot take ibuprofen as it upsets his stomach, currently taking ibuprofen 800 mg. PE: Musculoskeletal: Lumbar: decreased AROM, flexion with pain. Assessment: 1. Contusion of the lumbar region, 922.31, 2. Abrasion back, 911.0. Plan: DC ibuprofen, start Anaprox ds 1 PO BID with food, PT, recheck in one week. Modified activity with restrictions: no lifting over 25 lbs, no squatting and/or kneeling.

11-08-12: Visit Notes at xxxxxx dictated by PT. Claimant reports no improvement with continued low back pain at 9/10. Assessment: Overall progress is as expected. Plan: recommend continuing PT x1 more visit to progress toward the previously set goals.

11-16-12: Progress Note at dictated by DO. Claimant stated he continues to have a lot of pain that is worse now; pain meds not helping. PE: Musculoskeletal: Lumbar: unable to fully squat without pain difficulty standing on heel/toes, positive Waddell's distraction and positive Waddell's regional test, positive Waddell's tenderness, positive Waddell's over reaction. Assessment: 1. Contusion of lumbar region 922.31. Plan: claimant is not progressing as expected and feels he is getting worse. Ortho eval ordered. DC Anaprox, start Flexeril 5mg 1-2 PO QHS PRN pain, continues modified duty.

11-27-12: History and Physical Examination of the Thoracic and/or Lumbosacral Spine dictated by MD. The claimant describes his back pain as intermittent, dull ache, and sharp/stabbing. The claimant's leg pain began on 10/31/12 with reported intermittent radiation pain into the right leg with radiation of pain into buttock, thigh, calf, and foot. He reported numbness of the foot and intermittent tingling in the right leg and tingling in the thigh and calf. He stated that the pain is made better by nothing and made worse by bending and sitting. He reported recent PT for four days, which includes exercises with no improvement. Impression: The claimant has a history of low back pain since his injury in October. Physical exam today reveals no evidence of neurologic deficit. He had a few days of therapy at. He has continued pain in his lower back radiating into the right leg. C-rays if the lumbar spine reveal disc space narrowing at L5-S1. We will obtain an MRI for further recommendation.

12-06-12: MRI Lumbar WO dictated by MD. Impression: 1. Advanced disc height loss at L5-S1, with diffuse 5 mm spondylotic disc protrusion minimally effacing the proximal right S1 nerve root sleeve and contacting the exiting right L5 nerve. 2. Mild bilateral disc mediated neural foraminal narrowing at L5-S1. 3. 2mm right foraminal disc protrusion at L4-L5, without nerve root compromise. 4. Mild facet arthrosis at L4-L5 and L5-S1.

12-11-12: Office Visit Note dictated by MD. After reviewing the MRI findings, recommend a referral to Pain Management for injections in his back as well as possibly additional PT. Follow up in one month.

12-18-12: New Patient Initial Consultation dictated by MD, PA. The claimant reported back pain located in the bilateral lower lumbar paraspinal region described as aching, shooting, stabbing, dull, pinching and pressure, constant worse in the evenings and is varying in intensity. The pain is made worse by lumbar flexion, lifting, bending and pulling. The pain is made better by changing positions, rest, ice compresses and medications. The low back pain is worse since onset. ROS: muscle pain, spine pain, numbness or tingling, isolated weakness. Exam Special Neuro: Straight leg raise testing while seated was positive on the right for radiating leg pain. Exam Lumbar Spine: usual pain is aggravated with flexion. Impression/Diagnosis: Radiculopathy secondary to Lumbar Disc Displacement 722.10 right L5 and right S1 level(s). Recommendations: Lumbosacral Spine: The claimant has suffered for greater than 2 weeks form radicular symptoms without a specifically identifiable spinal

nerve level etiology. There are documented findings on examination supporting a radicular pathology. MRI findings are consistent with multilevel pathology, either central, lateral recess or foraminal stenosis, likely the cause of radicular pathology; however exact source of pain is ambiguous. PT/NSAIDs/muscle relaxants have failed to control symptoms. There is no positive Waddell's sign or evidence of psychological pathology that would preclude performance of the recommended transforaminal injection procedure. Lumbar Selective Nerve Root Block/Transforaminal Epidural Steroid Injection: Right L5 and S1. Follow up with referring physician.

01-22-13: Initial Medical Report dictated by MD. Claimant reported low back pain. ESI has not been approved. Objective Clinical Findings: Claimant appears in moderate distress due to his pain. Examination of the lumbar spine reveals tenderness over the midline and paraspinally. There is tenderness over the right sciatic notch. Lumbar motion is restricted in all planes with pain. Straight leg test is positive on the right. Kemp's test is positive bilaterally. There is diminished sensation of the right lower extremity as compared to the left. Initial Diagnosis: lumbar contusion, lumbar sprain/strain (N/C), lumbar radiculitis (N/C). Treatment Plan: Claimant is to undergo active physical rehabilitation to improve AROM, strength and function of the lumbar spine and lower extremities; medications: Norco 5/325 mg PO TID and Flexeril 10mg daily; Work status: continue working with restrictions per the DWC-73 form; follow-up her in two weeks.

03-01-13: Subsequent Medical Report dictated by MD. Claimant presented with persistent back pain. Objective Clinical Findings: Examination of lumbar spine reveals moderate tenderness of lumbar paraspinals bilaterally. Tenderness also noted of bilateral SI joint. Lumbar ROM is restricted with increase in pain. Straight leg test is positive on the right. Kemp's test is positive bilaterally. There is diminished sensation of the right lower extremity as compared to the left. Treatment Plan: pending therapy, pending DD for extent of injury, medications: Norco and Flexeril, work status: continue working with restrictions, follow up here in four weeks.

04-01-13: Functional Capacity Assessment dictated by. Occupational Demands vs. FCE Results: The claimant's occupational demand as an electrician requires Heavy PDL. According to the results of the evaluation the claimant's currently performing at a Sedentary PDL, which indicates a moderate functional deficit. The claimant was unable to complete protocol due to severe lumbar spine pain and discomfort. Table LC2-Test Endpoint Conditions: Psychological: Voluntary test termination by the claimant based on complaints of fatigue, excessive discomfort, or inability to complete the required number of movements during the testing interval (cycle).

05-08-13: UR performed by MD, MPH, CMRO. Reason for denial: Lumbar MRI on 12/21/12 reportedly showed L5-S1 spondylitic disc protrusion. Right L5-S1 transforaminal ESI was certified on 1/9/13 based on medical necessity only. It is unclear if that injection was ever performed. FCE on 4/1/13 reportedly showed

sedentary physical capability. However, this was not based on the static testing as the claimant did not perform any dynamic lifting. The request is for 80 hours of work conditioning. Recommend adverse determination. The reported mechanism of injury is consistent with a contusion. This should have resolved long ago without any residual. Moreover, there is inadequate objective evidence of a mismatch between claimant's physical capabilities and his job demands. The normal ADL's. Review of the static strength showed similar lack of effort with push/pull of only 10 lbs. The claimant should have been able to apply more force by simply leaning and using his weight. The request for work conditioning is not consistent with ODG criteria.

05-15-13: Request for Reconsideration dictated by DO. The claimant requires a Heavy PDL to return to work and is currently at a sedentary PDL. Conclusion: It is unfortunate that the clinical facts indicating the medical necessity of work conditioning for the claimant were not considered at the time of the initial request. Medical probability indicates that the claimant has a great potential to benefit from the work conditioning program. As a result, it is my professional duty to respectfully request reconsideration for 80 hours of work conditioning for the claimant, which will allow us to return him to unrestricted work duty and achieve case resolution.

05-21-13: UR performed by MD, MPH. Reason for denial: Recommend upholding the initial adverse determination. The mechanism of occupational injury is a contusion. This is an intrinsically self resolving condition with no permanent impairment. The FCE is not a valid FCE. Choosing not to perform any dynamic lifting is not the same as not being able to perform lifting. As pointed out earlier, zero dynamic lifting is not compatible with performing ADLs. The FCE demonstrates a lack of desire as opposed to a lack of physical function.

05-29-13: Designated Doctor Report and DWC form(s) dictated by, DC. Diagnosis: 1. 922.31 Contusion of back, 2. 911.0 abrasion or friction burn of trunk, without mention of infection. Based on examinations, radiographic studies and other objective symptomatology, the claimant did receive the above stated thoracic spinal injuries as a result of the noted accident but has not reached a level of MMI at this time and does therefore, not qualify for an impairment rating evaluation.

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

Denial of 80 hours of work conditioning is upheld and agreed upon. Per ODG Pain Chapter, request exceeds ODG recommended 30 hours of work conditioning over 4 weeks. Also there is psychosocial barrier to recovery in that current capability is Sedentary and job requirements are Heavy, therefore a gap too large to be bridged by work conditioning. Therefore, work conditioning is an inappropriate level of rehabilitation. Also, there is lack of information as to whether lower levels of care – such as invasive injections/procedures have been ruled out or exhausted – particularly given submitted information regarding

consideration of Lumbar Epidural Steroid Injection. In conclusion, after reviewing the medical records and documentation provided, the request for 97545 Work Conditioning x80 Hours, 97546 Work Conditioning Add-On is denied.

Per ODG:

<p>Work conditioning, work hardening</p>	<p><b>Criteria for admission to a Work Hardening (WH) Program:</b></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> <p>(4) <i>Functional capacity evaluations (FCEs):</i> 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.</p> <p>(5) <i>Previous PT:</i> 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.</p> <p>(6) <i>Rule out surgery:</i> The patient is not a candidate for whom surgery, injections, or other treatments would clearly be warranted to improve function (including further</p>
--	--

	<p>diagnostic evaluation in anticipation of surgery).</p> <p>(7) <i>Healing</i>: 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.</p> <p>(8) <i>Other contraindications</i>: 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.</p> <p>(9) <i>RTW plan</i>: 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.</p> <p>(10) <i>Drug problems</i>: 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.</p> <p>(11) <i>Program documentation</i>: 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.</p> <p>(12) <i>Further mental health evaluation</i>: 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.</p> <p>(13) <i>Supervision</i>: 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.</p> <p>(14) <i>Trial</i>: 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.</p> <p>(15) <i>Concurrently working</i>: 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.</p> <p>(16) <i>Conferences</i>: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.</p> <p>(17) <i>Voc rehab</i>: 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.</p> <p>(18) <i>Post-injury cap</i>: 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</p>
--	--

	<p>complex programs may also be justified as early as 8-12 weeks, see <a href="#">Chronic pain programs</a>).</p> <p>(19) <i>Program timelines:</i> 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.</p> <p>(20) <i>Discharge documentation:</i> 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.</p> <p>(21) <i>Repetition:</i> 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.</p> <p><b>ODG Work Conditioning (WC) Physical Therapy Guidelines</b></p> <p>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 <a href="#">Physical therapy</a> 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.</p> <p>Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.</p>
--	---

**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)**