

AccuReview

An Independent Review Organization

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Notice of Independent Review Decision

[Date notice sent to all parties]: July 7, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Total 80 hours, 10 units Initial Work Hardening; 60 units Additional hours of Work Hardening

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:

09-30-10: MRI Shoulder Right W/O Contrast at

10-18-10: Office Visit

11-04-10: Office Visit

11-04-10: Operative Report

12-06-10: Follow-up Visit

Xx/xx/xx: Employers First Report of Injury or Illness

01-10-11: Right Shoulder X-Ray 3 Views

01-20-11: MRI Shoulder Right W/O Contrast

01-21-11: Notice of Denial of Compensability/Liability and Refusal to Pay Benefits

02-15-11: MRI Shoulder Right W Contrast at Radiology & Imaging

02-15-11: Arthrogram Shoulder S and J FL Arthro Shoulder Right INJ

03-16-11: Letter for Injury

04-11-11: Follow-up Visit

04-12-11: Initial Orthopaedic Consultation
06-20-11: Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease
12-20-11: Decision and Order at Department of Insurance Division of Workers' Compensation dictated by Hearing Officer
01-04-12: Notice of Disputed Issue(s) and Refusal to Pay Benefits
06-02-12: Designated Doctor Evaluation at Management Solutions
06-02-12: FCE
06-11-12: Texas Workers' Compensation Work Status Report
09-05-12: Mechanism of Injury
09-18-12: Initial Narrative Report
09-25-12: Initial Functional Capacity Evaluation
09-25-12: Texas Workers' Compensation Work Status Report
10-29-12: Addendum Post DD-RME at Evaluating Center
10-29-12: Workers' Compensation Work Status Report
11-08-12: Decision at Department of Insurance Division of Workers' Compensation
11-26-12: Office Visit
11-28-12: SOAP Progress Record
11-29-12: SOAP Progress Record
12-03-12: SOAP Progress Record
12-04-12: Initial Interview at Chronic Pain Management
12-04-12: Updated Request for Services at Chronic Pain Management
12-06-12: SOAP Progress Record
12-12-12: SOAP Progress Record
12-18-12: SOAP Progress Record
12-19-12: Office Visit
12-19-12: SOAP Progress Record
01-17-13: Office Visit at Rehab Center
01-28-13: Appeal Decision at Department of Insurance Division of Workers' Compensation
01-31-13: SOAP Progress Record
02-12-13: Notice of Independent Review Decision
03-05-13: SOAP Progress Record
03-06-13: SOAP Progress Record
03-07-13: SOAP Progress Record
03-08-13: SOAP Progress Record
05-14-13: Functional Capacity Evaluation
05-21-13: Office Visit at Rehab Center, LLC
05-30-13: Evaluation
06-04-13: Preauthorization Request
06-07-13: UR performed
06-10-13: Request for Reconsideration
06-17-13: Ur performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who is employed at time of injury was injured while at work on xx/xx/xx when she pulled herself up using the toilet paper dispenser with

her right arm and felt her shoulder pull experiencing immediate pain. The injured region is the right rotator cuff.

09-30-10: MRI Shoulder Right W/O Contrast. Impression: 1. High grade tear of the supraspinatus and anterior infraspinatus insertion along articular fibers. 2. Subscapular tendinosis. 3. Prominent glenohumeral joint effusion including subscapularis recess collection with contained debris or synovial proliferative change. There is extensive propagation of fluid along the biceps tendon sheath as well as propagation of edema along the anterior border of the humerus which may relate to extravasation of joint fluid versus short head of the biceps brachii strain. 4. Edema surrounding the inferior joint capsule which may be related to capsular sprain or partial thickness tear. 5. Glenohumeral joint osteoarthritis particularly affecting the posterior glenoid margin as well as acromioclavicular joint osteoarthritis with scant adjacent bursitis.

10-18-10: Office Visit. Chief complaint: pain-right shoulder. Subjective: The claimant stated that she rolled out of bed and fell to the floor landing on the shoulder on October 13, 2013, which she has done multiple times. Her pain level is 9/10 in the shoulder. She has had steroid injections in the shoulder. Objective: On physical examination of the right shoulder, abduction is 90 degrees, adduction is 30 degrees, forward flexion is 160 degrees, extension is 45 degrees, external rotation is 80 degrees, internal rotation is 60 degrees. She has weakness, 3/5 strength in the palm down position and 4/5 strength in the palm up position. Resisted external rotation is at 3/5. She has significant tenderness in the anterolateral aspect of the shoulder, flexion of the elbow shows minimal pain. On resisted supination, she has minimal discomfort in the shoulder. Assessment: Torn rotator cuff – right shoulder, Impingement syndrome – right shoulder. Plan: As she has failed conservative treatment with repeated injections and based on her MRI is unlikely to improve with only physical therapy, my recommendation is for rotator cuff repair, subacromial decompression and evaluation of the biceps at that time for possible tenodesis.

11-04-10: Operative Report. Preoperative Diagnoses: 1. Right shoulder rotator cuff tear. 2. Impingement syndrome. Postoperative Diagnoses: 1. Right shoulder rotator cuff tear. 2. Impingement syndrome. 3. Severe glenohumeral arthrosis. 4. Multiple loose bodies.

12-06-10: Follow-up Visit. Subjective: Claimant continues to complain of constant pain. She stated that hydrocodone is not helping and she is not using sling. She reported pain radiates from her shoulder down to the wrist and is anterior. She stated that she has been typing and washing her hair using the right upper extremity. Objective: Physical examination of the right shoulder shows the incisions are healing well with no signs of infection. Assessment: Noncompliance, status-post shoulder surgery (11-4-10)-right shoulder. Plan: Refilled her pain medication. Advised her to use her sling and avoid actively using her arm to shampoo her hair, raise her arm, etc. She needs to totally immobilize her right shoulder. Follow up in one month.

01-10-11: Right Shoulder X-Ray 3 Views. X-rays show 2 anchors present in the greater tuberosity humerus. They appear to be in good position. The AC joint appears to have been at least partially resected. The glenohumeral joint appears to be with minimal degenerative changes.

01-20-11: MRI Shoulder Right W/O Contrast. Impression: 1. Extremely limited due to extensive motion artifact and metallic artifact from previous surgery. There is extensive edema/morphous signal along the expected location of the distal supraspinatus and anterior infraspinatus tendon insertions suggestive of at least partial thickness tearing relatively high grade in severity which may be rather extensive. A full-thickness component is not excluded at this time and a follow-up study will be of benefit. If the claimant cannot tolerate additional MR, a CT arthrogram may be likewise be of benefit. 2. Extremely limited evaluation of glenohumeral joint and adjacent labrum. Association joint effusion is however noted. 3. Acromioclavicular joint osteoarthritis status post subacromial decompression with scant fluid identified within the adjacent bursa.

01-21-11: Notice of Denial of Compensability/Liability and Refusal to Pay Benefits at Risk Management. The claimant's alleged injury of xx/xx/xx did not arise out of or in the course and scope of her employment for the employer; therefore, pursuant to TEXAS LABOR CODE 406.031, we deny the claimant has a work related injury, and deny compensability and disability.

02-15-11: MRI Shoulder Right W Contrast. Impression: 1. Attenuation of articular fibers of the supraspinatus consistent with a high grade re-tearing. A few intact bursal fibers appear to remain. 2. Fraying/tendonosis of the anterior infraspinatus. The bulk of the posterior fibers remain intact. 3. Contrast extravasation limiting evaluation of the subacromial bursa. Intrasubstance signal may be due to component of partial-thickness tearing or tendonosis cannot entirely be excluded and may be followed for stability. 4. Debris or loose body within the biceps tendon sheath. 5. Glenohumeral and acromioclavicular joint degenerative changes as described including focal intense marrow edema affecting the superomedial border of the humeral head which may be degenerative or contusional in nature. 6. Please note a native nonenhancing subacromial/subdeltoid bursitis is identified.

03-16-11: Letter for Injury, the claimant re-tore her right shoulder while lifting herself off the toilet.

04-11-11: Follow-up Visit. Claimant complained of right shoulder pain and limited range of motion. Objective: On examination of the right shoulder, abduction is 90 degrees, adduction is 10 degrees, forward flexion is 120 degrees, extension is 45 degrees, external rotation is 45 degrees, internal rotation is 30 degrees. She has weakness, 3/5 strength in the palm down position. She has significant tenderness in the anterolateral aspect of the shoulder and anterior aspect of the shoulder. Assessment: Re-tear of rotator cuff – right shoulder, Pain and weakness – right shoulder. Plan: The plan is for injection of the shoulder, physical therapy and follow-up in 6-8 weeks.

04-12-11: Initial Orthopaedic Consultation. Claimant reported restriction of the ROM of her right shoulder. Movement is associated with mark pain on attempted motion and reported weakness of the right shoulder and arm at this time. PE: Right Shoulder: She has 5 healed arthroscopic portals with a normal contour. She has AC joint tenderness and generalized tenderness of the shoulder, especially of the anterior shoulder joint. She has a positive cross-arm and lift-off test. AROM: flexion: 178 degrees; extension: 50 degrees; abduction: 178 degrees; adduction: 50 degrees; internal rotation: 70 degrees; external rotation: 80 degrees. PROM: flexion: 178 degrees; extension: 50 degrees; abduction: 180 degrees; adduction: 50 degrees; internal rotation: 80 degrees; external rotation: 90 degrees. Diagnostic Impression: Recurrent rotator cuff tear, right shoulder.

12-20-11: Decision and Order dictated by Hearing Officer. Decision: The claimant sustained a compensable injury of xx/xx/xx. The claimant does not have disability resulting from the compensable injury of xx/xx/xx from 1/28/11 through the date of this hearing.

01-04-12: Notice of Disputed Issue(s) and Refusal to Pay Benefits. The claimant's compensable injury is limited to a right shoulder sprain/strain only. No other condition naturally resulted from or was affected by the original incident. All other injuries, conditions, diagnoses and/or symptoms related to another part of the claimant's body are denied as not resulting from the accident.

06-02-12: Designated Doctor Evaluation. As per FCE, the examinee is allowed to return to work as of 6/5/12 without restrictions. The examinee was self limiting during testing. Treatment History: The claimant had 2 weeks of physical therapy, chiropractic care, and tens unit: PT and indicated that it has helped her condition except for the tens units: PT. Current Medication: Norco. Injections: Trigger point in shoulder and cortisone injection in shoulder. Pending treatments: physical therapy and chiropractic care. Work Status: she has not worked since her injury. Claimant's pre-injury job requirements: standing, sitting, pushing/pulling, walking, climbing stairs/ladders, grasping/squeezing, reaching, reaching overhead, keyboarding, driving, lifting/carrying up to 15 lbs for 30 min per day. Claimant stated her pain 4/10 currently and 10/10 at worst, 4/10 at best. She reported her pain consistent in nature and increased pain with any movement that is decreased by exercise, medication, rest and chiropractic care. Return to work determination: with restrictions. Extent of Injury Determination: After review of all submitted record it is my opinion that this partial right shoulder disability is a re-tear of her tendon and is due to the injury of xx/xx/xx. The re-tear was evident in the right shoulder on 2/15/11. The history of her pulling herself up off the toilet is consistent with this injury.

06-02-12: FCE at Genesis. Conclusion: Based on the examination the claimant performed at a SEDENTARY physical demand level; however, these results are based on self limiting factors due to an unrelated health issue. Therefore, it is reasonable to conclude that if she did not have the pre-existing health issues she would be able to perform at a higher function.

09-05-12: Mechanism of Injury. It is reasonable medical probability that when the claimant pulled in an attempt to arise from the commode the rotator cuff tendon tore. It is within medical probability that this mechanism of injury enhanced or accelerated her shoulder condition especially considering she was still recovering from the recent surgery. But for the above mentioned mechanism of injury, she would not have injured her right shoulder rotator cuff tendons. As this right shoulder injury relates to her ability to work, she would have a great deal of difficulty using her right shoulder or right upper extremity due to this injury and her likely need for additional surgery. In addition to this, she has balance problems that she requires the use of a cane for at times, but based on what I have seen, I have suggested that she uses a walker to avoid falling. With this in mind, the right shoulder strength and stability becomes even more serious injuries resulting from falling. Therefore, I would recommend significant limitations including the inability to use the right shoulder or right upper extremity for any stability control necessity, lifting, or outreach work.

09-18-12: Initial Narrative Report. Chief complaint: right shoulder pain and dysfunction. PE: Palpation revealed significant tenderness and pain throughout the glenohumeral region. Acromioclavicular joint tenderness was noted. Rotator cuff tenderness lateral and superior to the glenohumeral was noted. ROM: abduction 90 degrees, forward flexion 86 degrees, extension 40 degrees, internal rotation 35 degrees, external rotation 65 degrees. Manual muscle testing, right shoulder: 4/5 with abduction, internal rotation, forward flexion, and external rotation secondary to pain. Assessment: Claimant continues to experience significant diminished ROM in her right shoulder as well as significant pain. The physical therapy did provide some lowered pain level in the shoulder, but was discontinued. Treatment Plan: Request 6 additional physical therapy treatment sessions. The claimant may not be a good candidate for surgical intervention. Focus of teaching the claimant a HEP and stretches to help regain and maintain ROM and overall lowered pain levels.

09-25-12: Initial Functional Capacity Evaluation. Required job level: Medium; current PDL: Sedentary. Impression: Consistent effort was demonstrated during the testing process and tasks were discontinued with pain primarily limiting functional ability. Observation revealed maximum exerted effort. The results of the evaluation indicate that there is a significant difference between required job level and current functional ability level. A work hardening program may be appropriate to help improve the functional ability that would allow her to achieve higher level of functional ability. If there are significant psychological components that are aiding in the diminished functional ability, then a chronic pain management program would be more appropriate.

11-08-12: Decision at Department of Insurance Division of Workers' Compensation dictated by Hearing Officer. Decision: The compensable injury of xx/xx/xx does not extend to include a right shoulder re-tear of the rotator cuff. The claimant did not have disability resulting from an injury sustained on xx/xx/xx, from 12/28/11 through the date of this hearing.

11-26-12: Office Visit. Claimant reported the determination that she has suffered a right shoulder sprain and strain injury from workers' compensation hearing. As a result, we cannot pursue treatment per ODG guidelines. Clinically, the claimant continues to experience pain in her shoulder with ROM unchanged. Requesting physical therapy consisting of 6 visits over 3 weeks.

12-04-12: Initial Interview. Impressions: The interviewer feels that there is a strong indication that the claimant is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety which are secondary to her work-related injury. The following diagnosis is based on the information reported by the claimant and this clinician's observations during the face-to-face interview: DSM-IV: Axis I: 307.89, Pain disorder with both psychological factors and a general medical condition; Axis II: V71.09, deferred; Axis III: 840.9; Axis IV: Chronic pain, financial struggles, multiple social losses, and problems with family; Axis V: GAF=55. Recommendations: It is recommended that the claimant be seen for 6 sessions of individual psychotherapy to address high levels of stress and depressive symptoms to help her increase management of her chronic pain. She has a high potential to benefit from therapy and psychological interventions given her employment history and her motivated drive to remain as productive as possible.

12-04-12: Updated Request for Services. Impressions: The interviewer feels that there is a strong indication that the claimant is experiencing pain that is creating interference in her life. It appears as though she is having long-term adjustment problems of depression and anxiety which are secondary to her work-related injury. The following diagnosis is based on the information reported by the claimant and this clinician's observations during the face-to-face interview: DSM-IV: Axis I: 307.89, Pain disorder with both psychological factors and a general medical condition; Axis II: V71.09, deferred; Axis III: 840.9; Axis IV: Chronic pain, financial struggles, multiple social losses, and problems with family; Axis V: GAF=55. Clinical Rationale for Requested Procedure(s): We are requesting the claimant participate in 10 sessions of behavioral multidisciplinary chronic pain management program. Without this type of intensive intervention her maladaptive beliefs and thoughts are likely to continue in a downward spiral as the chronic pain continues to affect the claimant's quality of life. It is crucial that she receive other necessary components, which are not provided in individual therapy, to help obtain the tools needed to succeed and increase overall level of functioning. Summary: The pain resulting from her injury has severely impacted normal functioning physically and interpersonally. Claimant reported frustration and anger related to the pain and pain behavior in addition to decrease ability to manage pain. Claimant has reported high stress resulting in all major areas of life. The claimant will benefit from a course of pain management. It will improve her ability to cope with pain, anxiety, frustration, and stressors, which appear to be impacting her daily functioning.

12-19-12: Office Visit. Claimant presented after completion of 6 preauthorized physical therapy session for the right shoulder sprain and strain injury with positive improvements. ROM has improved: Currently: forward flexion 110 degrees, abduction 100 degrees, extension 50 degrees, internal rotation 45 degrees, external rotation 80 degrees. Noted claimant has improvement in functional ability. Requesting additional physical therapy, ODG recommends 10 visits for sprain strain of the shoulder, and recommend 4 additional sessions therefore.

05-14-13: Functional Capacity Evaluation. Summary: Required: Medium, Current PDL: Light. Impressions: There continues to be a deficiency between the required job levels and the claimant's required job levels and her current functional ability. Recommend a work hardening program to help achieve maximum medical improvement and hopefully allow her to return to work at a medium physical demand level. There were elements of depression and anxiety the claimant has exhibited that would also be treated somewhat in a work hardening program.

05-21-13: Office Visit. Claimant continued to have complaints of right shoulder pain. Her PT was completed in March and since that time she has been performing HEP only. She continues to experience pain and decreased ROM. Current ROM: forward flexion 120 degrees, abduction 110 degrees, extension 50 degrees, internal rotation 55 degrees, external rotation 80 degrees. Strength function continues to be diminished and measured at 4/5 secondary to pain. Recommended work hardening program as she has shown progress through physical therapy and we have seen a plateau with regard to improvement. She continues to see diminishment in function with regards to her right shoulder and is not a good surgical candidate at this point given her age. However, improvement in functional ability and strength would greatly assist her in her ability to achieve maximum medical improvement.

05-30-13: Evaluation. Chief complaint: pain in right shoulder. DSM-IV: Axis I: 307.89, Pain disorder with both psychological factors and a general medical condition; Axis II: V71.09, deferred; Axis III: 7193.41; Axis IV: Pain and financial struggles; Axis V: GAF=60. Summary: The claimant has behavioral issues that will be appropriately addressed in a multidisciplinary program. She should be treated daily in a multidisciplinary program with both behavioral and physical modalities. The claimant does not display any psychosocial or pain behaviors that need to be addressed in a different type of program or which will prevent successful participation and return to work following completion of a multidisciplinary program.

06-07-13: UR performed. Reason for denial: The claimant is over 2 years status post injury. The ODG treatment guidelines do not recommend work hardening for injuries past 2 years. There is no job description from the employer outlining specific job duties that would require her to lift at a Medium physical demand level. The request is not in keeping with the ODG guidelines. The claimant

should do just as well with a self-directed home exercise program at this time. Recommend non-approval of 80 hours of work hardening.

06-10-13: Request for Reconsideration. The claimant is two years and five months post injury, however, with the history of the injury and not until after the designated doctor's evaluation completed in June 3023 and mechanism of injury was consistent with the right partial tearing of the right rotator cuff injury. After this was completed, the lawyers had to be involved and the extent of injury was not even determined until the late summer of 2012. Therefore, no treatment could have been administered until after this issue was resolved. As pertaining to the job description of the claimant's current position, she has been unable to return to work for over two years and has lost her job because of her inability to return to work. When this occurs, vocational consultations should be available if the claimant has no job to return to. That is the case here and therefore is required to have physical ability and least at a medium physical demand level. The claimant is not a good candidate for surgical interventions as she has a history of prior rotator cuff repair and therefore, a work hardening program is the perfect option since the claimant intends on returning to work and requires a higher functional ability than just a light level. There has been a significant amount of deconditioning that is also being addressed and treated in a work hardening program versus just a home exercise program as suggested by the case reviewer.

06-17-13: Ur performed. Reason for denial: The current request for work hardening is not medically necessary. First, there was insufficient information to establish medical necessity for this request. There was no documentation of functional capacity evaluation, behavioral health assessment, job description for projected return to work, and evidence of a mismatch between work requirements and current capabilities. Next, there was no specific documentation suggesting that this female intends to return to the workforce, as such, the request is inconsistent with evidence – based recommendations. Recommend non-certification.

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

The previous denial of 80 hours/10 units of initial work hardening and 60 hours of additional work hardening is agreed with and upheld since the very first criteria for work hardening under ODG Pain chapter guidelines is recommendation by a physician or nurse case manager and a prescription has been provided; neither of these are noted in the submitted clinical information. Therefore, after review of the medical records and documentation provided, the request for Total 80 hours, 10 units Initial Work Hardening; 60 units Additional hours of Work Hardening is denied.

Per ODG:

Work conditioning, work hardening	Criteria for admission to a Work Hardening (WH) Program: (1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided. (2) <i>Screening Documentation:</i> Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the
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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.

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)**