



Notice of Independent Review Decision

March 1, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97545 Work Hardening Program 5 x week x 2 weeks and 97546 Work Hardening Add on

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

Board Certified in Occupational Medicine, American Board of Preventive Medicine

REVIEW OUTCOME:

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

- Upheld (Agree)
- Overturned (Disagree)

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Partially Overturned (Agree in part/Disagree in part)

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:

- 10-1-12, MD, office visit
- 10-8-12, MD, EMG/NCV
- 11-1-12, MD, operative procedure
- 11-15-12, MD, operative procedure
- Follow up with, MD, on 12-27-12
- 12-28-12 Functional Capacity Examination
- Behavioral Health assessment on 1-2-13
- 1-17-13, DC, office visit
- 1-17-13 DC, prescription
- 1-23-13, letter
- 1-24-13, MD., performed a UR
- Request for Work Hardening Program on 1-24-13
- 1-30-13, MD, medical evaluation
- Appeal for Work Hardening Program on 2-4-13
- 2-8-13, DO., performed a UR
- Request for a review by an independent review organization on 2-13-13
- 2-13-13, notice
- 2-18-13, DC, Letter to independent review organization
- 2-19-13 Fax Cover sheet from AAA Medical Solutions

PATIENT CLINICAL HISTORY [SUMMARY]:

xxxx, MD, exam shows right wrist/hand with volar wrist tenderness. Positive compression test, positive Tinel, and positive Phalen. Left wrist with positive Tinel and Phalen. Diagnosis: Carpal tunnel syndrome. Mononeuritis arm unspecified, therapy drug monitor. Plan: Bilateral upper extremity EMG/NCS. Work status as per treating doctor. Nighttime wrist bracing. Ultram. Complete therapy. Follow up 1-2 weeks with EMG/NCS results.

10-8-12 EMG/NCV interpreted by, MD, showed evidence for moderate right greater than left median sensory mononeuropathies in the wrist/palm segment, with conduction block and/or loss of sensory axons to digit 2. Findings are consistent with

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the typical demyelination and possibly axonal pathophysiology of median neuropathy in carpal tunnel syndrome. There is no evidence of left or right cervical radiculopathies, brachial plexopathies, focal ulnar neuropathies in their elbow or wrist segments, or upper limbs polyneuropathies.

11-1-12, MD, preoperative diagnosis: Right carpal tunnel syndrome. Postoperative diagnosis: Right carpal tunnel syndrome. Procedure: Right carpal tunnel release.

11-15-12, MD, preoperative diagnosis: Left carpal tunnel syndrome. Postoperative diagnosis: Left carpal tunnel syndrome. Procedure: Left carpal tunnel release.

Follow up with, MD, on 12-27-12, the claimant presents for postoperative follow up. He reports improving with therapy. Exam shows bilateral wrist surgical incision is clean/dry/intact/healed. There is mild wrist swelling and minimal hand/wrist stiffness. Diagnosis: Status post bilateral carpal tunnel release surgery on 11-1-12-further improving post op. Plan: Keep hands elevated. Work status as per treating doctor. Ultram. Complete approved hand therapy with treating doctor. Follow up in 3-4 weeks.

12-28-12 FCE shows the claimant is functioning at a Medium PDL. It was recommended the claimant participate in a work hardening or work conditioning program dependent on psychological testing.

Behavioral Health assessment on 1-2-13. Diagnostic impression:

AXIS I: Adjustment disorder with mixed anxiety and depression, chronic.

Occupational problem.

AXIS II: Deferred

AXIS III: CTS both right and left wrist, postop.

AXIS IV: Psychosocial stressors, physical health primary support group/marital, educational/school, occupational/work, economic/financial, legal/workers compensation system.

AXIS V: GAF 50, prior to injury GAF 75.

The evaluator reported that the claimant's readiness status for work hardening program is judged as good because of possibly/probably excessive maladaptive factors listed under clinical impressions, which are affecting, exacerbating, interfering with and/or delaying recovery from current work related medical condition.

1-17-13, DC, the claimant complains of left wrist pain that he rates a 3/10. The pain radiates from the left wrist up the left forearm. He complains of right wrist pain that he rates a 3/10. He has tingling of the 2nd and 3rd fingers on the right hand. The pain radiates from the right wrist up the right forearm. He reports feeling depressed/anxious, difficulty sleeping, and having "fears". Exam shows decreased left wrist ROM with pain. Right wrist ROM is decreased with pain. Diagnosis: Carpal tunnel syndrome of the right and left wrists-post op. Plan: Request for Work Hardening Program.

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1-17-13, DC, prescribed Work Hardening Program.

1-23-13, notes the claimant is a laborer for her company. His duties include digging holes for utility poles, using hand held post-hole diggers, shovels, rock bars, and on occasion jack hammers. These hole range in size from 7 to 10 feet deep and 20 to 30 inches wide.

Request for Work Hardening Program on 1-24-13.

1-30-13, MD, performed a Designated Doctor Evaluation. He certified the claimant has not reached Maximum Medical Improvement but is expected to reach Maximum Medical Improvement on 4-30-13. No report attached.

1-23-13 Bexar Pipeline and Utilities job description - the claimant is a laborer for the company. His duties include hand digging holes for utility poles, using hand held post-hold diggers, shovels, rock bars, and on occasion jack hammers. These holes range in size from 7 feet deep to 10 feet deep and 20 inches wide to 30 inches wide.

1-24-13, MD., performed a UR. Recommend adverse determination. The claimant is status post bilateral carpal tunnel release. The patient has completed the ODG maximum number of supervised rehab sessions post-op to-date. There is no employer-verified RTW PDL. The FCE that is provided has no evidence of physiological monitoring. Regardless, it demonstrates ability of lifting and carrying of 50 lbs and grip strength of 100 lbs that already meets the Heavy PDL. There is no description how carpal tunnel release would affect lifting and carrying ability at all since lifting and carrying ability is dependent predominantly on lower extremity strength as opposed to fine motor strength of the hands. There is also no plausible medical explanation how the patient would reasonable have developed any psychosocial issues regarding his carpal tunnel syndrome and carpal tunnel surgery. The patient used a Jack Hammer for one day, reported symptoms, was assessed, then diagnosed with CTS and underwent surgery and post-op rehab. This all happened within a matter of months.

Appeal for Work Hardening Program on 2-4-13. It is noted the claimant does want to be able to return to his previous job. He is and always has been a laborer. He reported that he does make good money at his previous job and that is where he wishes to return to for work. The claimant would be a good candidate for a work hardening program.

2-8-13, DO., performed a UR. She noted that spoke with Dr. on 2-5-13 and discussed the case. She noted there is not clear objective evidence of injury related functional deficits. Residual subjective complaints have not been adequately evaluated or addressed at lower levels. Ongoing use of multiple pain medications is not expected over 2 1/2 months out from last carpal tunnel release. It is also not clear what would have prevented ongoing conditioning via usual activities of life over the past 38 days since the FCE.

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Request for a review by an independent review organization on 2-13-13.

2-13-13 letter notes the aforementioned deadline for issuing the determination in the referenced IRO case number. If there are or will be any barriers to meeting this deadline, notify the URA/IRO Section at the earliest opportunity.

2-18-13, DC, notes the claimant is NOT able to meet the Physical Demand Level required by his job. He must be able to lift and carry up to 100 lbs. which presently he can only lift and carry 50 lbs. He must be able to constantly firmly grasp hand held post-diggers, shovels, rock bars and jack hammers, which presently he is unable to do. These holes which are all dug by hand range in size from 7 feet deep to 10 feet deep and 20 inches wide to 30 inches wide. The claimant does have his previous job waiting for him once he is able to meet his Physical Demand Level. With regards to his grip strength, as the evaluator tried to explain to the previous peer review doctor, the claimant can take a dynamometer and squeeze 100 lbs. of grip strength for 2 seconds of time, but he cannot sustain a constant grip of any object which would require substantial use of strength as his job would require. As he tried to explain to the peer review doctor on the Appeal, that being able to squeeze a dynamometer to 100 lbs. for 2 seconds does not qualify the claimant to be able to firmly grasp hand digging equipment for an 8 hour day. Presently, he is unable to perform this. Additionally, the claimant has developed some emotional issues related to his injury. The claimant has a 10 grade education. He is a very large, powerfully built man who has always relied on his ability to perform physical labor to make a living. After having both his right and left wrist surgeries, he has questioned whether or not he will be able to return to the life which he has always known, the life of performing hard physical labor.

2-19-13 Fax Cover sheet from AAA Medical Solutions - hand written note to Claims Evaluator.

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

Medical records reflect the claimant is status post bilateral carpal tunnel release. He has undergone the appropriate post op therapy. He has been unable to return to his previous PDL as a laborer. The claimant has met ODG criteria to be enrolled in a work hardening program. He has had a FCE, psychological clearance, and has been unable to return to his previous level of employment. Therefore, per ODG, the requested 97545 Work Hardening Program 5 x week x 2 weeks and 97546 Work Hardening Add on, is reasonable and medically indicated.

Per ODG 2013 Work hardening/work conditioning: Recommended as an option, depending on the availability of quality programs. [NOTE: See specific body part

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chapters for detailed information on Work conditioning & work hardening.] See especially the Low Back Chapter, for more information and references. The Low Back WH & WC Criteria are copied below.

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).

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- (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

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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.

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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)