

Health Decisions, Inc.

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Notice of Independent Review Decision

[Date notice sent to all parties]: August 28, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Additional Work Hardening 8 Hrs Day x 5xWk x 2Wks Cervical Spine – 97545
97546

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

This Reviewer is a Chiropractor with over 24 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:

06-03-13: Evaluation
06-04-13: Behavioral Health Assessment for Work Hardening
06-13-13: MMI Report
06-18-13: Followup Visit
06-25-13: Functional Capacity Evaluation
06-26-13: Work Hardening Request
07-11-13: Designated Doctor Evaluation
07-11-13: Functional Abilities Evaluation
07-16-13: Functional Capacity Evaluation
07-24-13: Work Hardening Continuation Request
07-30-13: UR performed
07-31-13: Letter
08-02-13: Complete Rationale for Preauthorization
08-05-13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured on xx/xx/xx. He tripped on a concrete curb that was muddy and wet, and consequently hit his head and left knee on the hard surface when he fell. Since the injury he has reported a continuation of the following symptoms: Balance problems, hearing loss (a buzzing sound in his right ear), weakness in both hands, memory problems, some outbursts of anger when he is triggered. Past treatment included medications, including Ultram 50 mg, Naprosyn 500 mg and Flexeril 5mg, physical therapy for his left knee strain and neck strain, cervical ESIs and bilateral cervical facet rhizotomy which helped minimally. Records documented a MRI of the Cervical Spine was completed on June 15, 2012 that revealed Acquired central canal stenosis at four cervical levels including C3-4, C4-5, C5-6 and C6-7. At each level there were broad-based posterior 4 mm disc protrusions diffusely flattening the ventral surface of the cervical cored. Central canal measured 5-7 mm at each level. There was also mild disc desiccation and spondylosis at the same four levels and mild disc space narrowing at C5-6 and C3-4. EMG/NCV performed on June 13, 2012 revealed abnormalities. It was also report that in addition, with multiple traumatic or entrapment neuropathies, the possibility of diabetes should be considered.

June 18, 2013, evaluated the claimant who wanted a letter stating that even with the nerve surgery he had, the cervical surgery that has been discussed is necessary. The claimant rated his pain 6/10. On physical examination, upper extremity strength was 5/5 bilaterally. Reflexes were 2+ bilaterally and sensation was normal. Assessment: C3 to C7 herniated nucleus pulpous with bilateral upper extremity radiculopathy. Plan: It was noted that surgical plans for decompressing C3-4, C4-5, C5-6, and C6-7 had been delayed consistently by the level of the claimant's hemoglobin A1C which was currently 8.7. The claimant was reported to be working with his primary care doctor to get control of his blood sugar so he can actually heal this kind of surgery.

June 25, 2013, a Functional Capacity Evaluation results indicated a Below Sedentary physical demand level for all lifting from floor or overhead tasks, and Light for all other lifting, pushing, pulling, and carrying tasks, as defined by the U.S. Department of Labor Physical Demand Characteristics of Work.
Recommend trial of Work Hardening Program

July 11, 2013, Functional Abilities Evaluation results indicated an inconsistent effort during the FCE and demonstrated elevated coefficients of variance on several tests. He provided submaximal effort and did not exhibit the physiologic and biomechanical changes normally observed when an individual is providing maximal effort. He was determined to be at a PDC of Indeterminate, which did not meet his self reported PDC of Heavy. However, based on the current testing, he should be considered at least capable of a PDC of Sedentary.

July 16, 2013, Functional Capacity Evaluation results indicated a Below Sedentary physical demand level for all lifting overhead tasks, and Light for all other lifting, pushing, and pulling tasks, and lower boundary of Medium for all carrying tasks.

July 24, 2013, requested continuation of work hardening after reportedly responding fairly well to conservative rehabilitation. It was reported that he demonstrated difficulty adjusting and coping with the work injury. That his mood had been negatively impacted by the pain, vocational loss and functional loss in the lumbar spine and that assessments clearly showed active symptoms of vocational distress and fear avoidance. A psychological assessment was completed. was requesting the claimant be allowed to attend and additional 10 sessions, eight hours a day, in order to return him to the workforce.

July 30, 2013, performed a UR. Rationale for Denial: The patient has completed 80 hours of work hardening to date. Current evidence based guidelines note that 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. Functional capacity evaluation dated 06/25/13 indicates that the patient's PDL for lifting from floor or overhead tasks is below sedentary and for all other tasks is light. Repeat functional capacity evaluation following completion of 10 sessions of work hardening indicates that overhead lifting remains limited to below sedentary PDL, light for all other lifting, pushing and pulling tasks and lower boundary of medium for all carrying tasks. Per telephonic consultation, request for additional work hardening is not warranted. Based on the lack of significant progress and slow progression seen with the initial trial of care and the fact that the patient remains a surgical candidate, it is unlikely that the patient will obtain significant gains in his persistent functional deficits with additional care or be able to properly return to work. For these reasons, the request is not medically reasonable.

July 31, 2013, wrote an appeals letter stating that it was true that the claimant did not demonstrate significant gains in his overhead lifting (still to be graded at a "below sedentary" PDL), but that was the only category in the PPE that he did not show progression. indicated that the claimant did show significant improvement in both the positional tolerance and materials handling categories and also showed significant improvement in his lifting, pushing, pulling, and carrying tasks. opined that the claimant had put forth good effort in the program and was 100% compliant and that the claimant was eager to get back to work in some form.

August 5, 2013, performed a UR. Rationale for Denial: The FCE testing performed on 7/11/13 after ten sessions of Work Hardening indicate submaximal effort on grip testing, 3 position pinch testing, step test, lifting tests, and others. This patient's NCV test rests are consistent with diabetes, which this patient has as a preexisting condition. I agree with the previous reviewer's determination to noncertify the request. There is very little functional progress documented after ten sessions of WH, and inadequate/invalid effort attempts on functional testing. This patient fails criteria for continuation in the WH program. There is no indication that this patient will make any clinically meaningful functional improvement with more WH.

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

The previous adverse determinations are upheld. The claimant is clearly a surgical candidate. Documentation does not support significant gains by subjective and objective improvement in functional abilities after 1-2 weeks of work hardening. Furthermore, Functional Capacity Evaluations should show consistency with maximum effort as documented within Official Disability Guidelines. This claimant clearly showed inconsistencies with effort during the Functional Capacity Evaluation on July 11, 2013. Therefore, the request for Additional Work Hardening 8 Hrs Day x 5xWk x 2Wks Cervical Spine – 97545 97546 is not found to be medically necessary.

PER OGD:

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.

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)**