

# Vanguard MedReview, Inc.

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## Notice of Independent Review Decision

September 23, 2014

### **IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Work Hardening Program X 80 Hours

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

This physician is a licensed Chiropractor with over 18 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.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

The claimant is a female who was injured at work on xx/xx/xx when she was exiting the bathroom. A co-worker came through the door which opened in her direction. She was struck, fell backward, and hit the floor, injuring her left shoulder, left upper arm, lower back, and left hip.

06/10/2014: Functional Capacity Evaluation. **Clinical Assessment:** has been diagnosed with 847.2 (Sprain Lumbar Region), 924.01 (Contusion of HIP) by her referring physician. Compensable areas included in this injury are: Lumbar, left hip. **HPI:** Mrs. reported her injury the same week. She continued working after her injury for 1 week. She has an attorney representing her regarding this claim. She describes her pain as increased when excessively moving in different ways. It causes her trouble with sleeping. Medications decrease pain. Pain is at a 2/10.

#### **Medications:**

Hydrocodone Bitartrate and Acetaminophen; Meloxicam **Assessments:** 1. The client has difficulty with this evaluation which may interfere with activities of daily living. 2. Evaluatee demonstrates functional deficits on evaluation today that would

benefit from additional medical attention, including therapy and/or diagnostic testing. 3. The evaluatee is unable to perform their regular job duties at this time. 4. The evaluatee required PDL is medium, however their current physical performance level is sedentary. The evaluatee was not able to demonstrate the ability to perform several key functions crucial to the safe performance of their normal work duties. **Recommendations:** 1. Any referrals the treating doctor feels is necessary that will help the evaluatee's condition. 2. The evaluatee would benefit from participating in an active physical rehab program. This program may be necessary in order to improve the evaluatees condition/functional tolerance, decrease pain and get the area of injury more stable as to avoid further injury, or re-injury to the area. 3. At this time, based upon the objective data obtained from this most recent functional evaluation, the evaluatee should continue with some form of continued active care to get their area of injury more stable as to avoid further injury or re-injury to the area. Care such as therapeutic exercise, active therapy, or some form of tertiary vocational therapy such as work hardening, or work conditioning which is designed, according to the evaluatee's injury, to improve tolerance to work related positions increase ROM, decrease pain, increase strength, educate, and help each evaluatee to hopefully avoid any future injuries. The treating doctor should make the ultimate decision on the care that is to be rendered. 4. According to the objective findings from the testing including dynamic lifting, static lifting, the clinical examination and all other activities previously mentioned in this report; it is my opinion that this evaluatee does not meet the requirements, safety, and performance ability to do their original job safely, effectively, and confidently (without restrictions). However, the evaluatee is capable of performing a different job with lesser physical requirements and job duties (possible with restrictions) which is at a lower physical demand level that the one in which they originally sustained the occupational injury.

08/01/2014: History and Physical Examination Work Hardening Program. **HPI:** Patient states although she was having pain at the time of injury, she continued to work. She finally decided to seek medical attention approximately 2 weeks after the date of injury secondary to the continued pain. The time of the evaluation patient received x-rays and was told that there were no bony abnormalities. Patient was given follow up treatment with being status post 5 physical therapy sessions. Patient now presents to the Clinic for further evaluation and treatment. At this present time patient is now status post 4 of 4 physical rehabilitation sessions. It was completed on July 24, 2014. At the time of her reevaluation it was recommended she be advance to WHP. In addition she is now status post an FCE on July 10, 2014. Patient has a work occupational demand PDL of medium and is currently testing at a PDL of sedentary. THE FCE report does support advancement to a WHP. Patient is also status post a DDE on July 8, 2014. It is professional opinion the patient has not met MMI however she is expected to do so on or about October 8, 2014. **Physical Examination:** Musculoskeletal: The left shoulder is noted for no evidence of any deformity, no edema, and no discoloration. There is decreased active ROM of the shoulder secondary to pain. There is diffuse tenderness to palpation over the soft tissue structures of the shoulder girdle. Otherwise the patient is neurovascularly intact. The left upper arm is noted for no evidence of any deformity, no edema, and no discoloration. The

patient is diffusely tender to palpation over the biceps and triceps muscles. Otherwise patient is neurovascularly intact. The lumbar region of the back is noted for no evidence of any deformity, no edema, and no discoloration. Patient is decreased active ROM of the lumbar spine secondary to pain. There is mild to moderate diffuse tenderness to palpation over the lumbar paraspinal muscles. This Otherwise patient is neurovascularly intact. The left hip region is noted for no evidence of any deformity, no edema, and no discoloration. It is decreased active ROM on internal and external rotation of the hip joint. There is diffuse moderate tenderness to palpation over the gluteal, hamstring, and quad muscles. Otherwise Otherwise patient is neurovascularly intact. **Impression:** Left shoulder pain, left upper arm myofascial, lumbar myofascial strain, left hip myofascial strain. **Plan:** 1. UDS ordered 2. WHP ordered 3. Patient medically clear for WHP 4. Form 73 completed 5. Follow up in one month 6. Norco 10-325 MG tab oral, sig: 1 po bid, 30 days, Qty 60 Ref: 0

08/12/2014: UR. **Rationale for Denial:** Peer to peer discussion has not been achieved despite calls to office. The request for 10 sessions of work hardening is not medically necessary. Guidelines state that the evidence for real work is far stronger than the evidence forcing related work. The record was missing evidence that modified duty is not available or that the patient has failed to return to work on prior occasions. As such, the request is not supported by available information. Recommend non certification.

08/29/2014: UR. **Rationale for Denial:** A peer to peer was successful. The claimant is currently 3 months post soft tissue injury. The job duty requirements that were provided were from the most recent employer where the claimant was terminated from, not from a job position that the claimant can return to currently following the program. The claimant was apparently terminated on 5/6/14. There is no indication of a job to return back to currently following the work hardening program. If the claimant does not have a specific job to return back to then the claimant will deteriorate back to the prior condition or status. Based on the submitted information the claimant does not meet the ODG Criteria for the current request. The claimant was diagnosed with a contusion of the hip and a strain/sprain of the lumbar spine, both of which should have resolved within the time frame already given since the date of injury. The claimant is currently diagnosed with a strain/sprain which resolves within 6 to 8 weeks based on the poor reviewed literature; the claimant has already exceeded this time frame. No objective findings have been identified on diagnostic studies which would have prevented the normal resolution of a strain/sprain with in the recommended time frame which the claimant has already exceeded. A claimant should be off work for at least 4 months prior to requiring a return to work program, since there is not enough time for the claimant to become deconditioned in the short time frame since the injury. The current request does not meet ODG criteria. No significant psych issues have been identified to support the current request for a multidisciplinary program. There is no evidence the claimant has reached a plateau from the PT already provided prior to this request. There is no evidence of attempts to return this claimant to modified work duties or full duty work status prior to the current request. A return to work duties has the best long term

outcome per ODG, even if the claimant requires a gradual transition to full duty work status. There is no written job verification form from the employer for the claimant to return to, nor is there a job description/job demand from the employer to support the current request. This claimant should be capable of modified work duties with a gradual transition to full duty work status as advised by ODG. Based on the documentation provided, objective and subjective findings, this request is not medically reasonable and necessary. Non-Authorization is advised.

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

The request for 80 hours of a Work Hardening program is not certified. Based on the medical documentation that has been reviewed, the claimant was involved in a work-related injury involving her left shoulder, left upper arm, lower back and left hip on the date of xx/xx/xx. The work hardening pre-authorization request noted the diagnosis as lumbar sprain/strain (847.2) and left hip contusion (924.01). The claimant has completed 8 sessions of physical therapy since the injury date of xx/xx/xx. There is no evidence that the claimant reached a plateau from the physical therapy already provided prior to this request. The records reveal that the claimant was terminated or released from employment on 5/6/2014. There is no documentation that shows that the claimant is eligible for current or future employability. Based on the ODG guidelines, the diagnosis of lumbar sprain/strain and left hip contusion should have been resolved between 6 to 8 weeks post injury date. In summary, the medical documentation that has been provided for this work hardening request does not support the requirements from ODG for the approval of this request. For these reasons, Work Hardening Program X 80 Hours is not medically necessary at this time and should be denied.

Per ODG:

#### **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)**