

# Vanguard MedReview, Inc.

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## Notice of Independent Review Decision

[Date notice sent to all parties]:

IRO CASE #:

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

Outpatient Medical Rehab Program (10) Sessions (4 hrs a day for 5 days a week for 2 weeks)

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

This reviewer is a Board Certified Physical Medicine and Rehabilitation doctor with over 16 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 on xx/xx/xx while working. She fell on hard dirt in a crack and hurt her right knee, right shoulder, and mid back.

11/10/2014: CT Right Knee. **Impression:** 1. Tricompartmental osteoarthropathy involving in order of diminishing severity, the medial femorotibial compartment, patellofemoral compartment, and lateral femorotibial compartment. 2. Hypertrophic changes of the proximal tibiofibular joint space. 3. No CT evidence of acute fracture or dislocation.

11/10/2014: CT Right Shoulder. **Impression:** 1. Low grade outlet stenosis. 2. No evidence of large pull thickness rotator cuff defect or occult/subacute osseous abnormality.

12/12/2014: CT Thoracic Spine. **Impression:** Osteoarthritic changes are identified in the thoracic spine. However, there is no disc herniation. No stenosis. No foraminal narrowing.

01/22/2015: Follow Up Evaluation. **Subjective:** Patient states she still has pain in shoulder and mid back of 7/10 and knee pain 6/10. **Physical Exam:** Cervical Spine: Full ROM. Side bending normal. Rotation normal. Flexion normal. Extension normal. Muscle spasm along the paraspinal muscle resolved. Trapezius muscle spasm is noted:

none. Tenderness to palpation is resolved. Upper extremities: Full ROM vascular intact. Sensation normal. Shoulder: Right: Remained the same. ROM abduction remained the same. Flexion remained the same, internal rotation remained the same. External rotation remained the same. Muscle \_\_\_\_\_ improving. Thoracic Spine: Inspection lateral deviation to remained the same. Kyphosis remained the same. ROM flexion remained the same. Extension normal. Rotation remained the same. Muscle spasm remained the same. Tenderness remained the same. Knee: Right: ROM flexion remained the same. Extension remained the same. Tenderness reported remained the same. Strength is remained the same. Medial collateral ligament normal. Lateral collateral ligament normal. Drawer test negative. **Diagnosis:** Right sprain of neck, right \_\_\_\_\_ sprain, right sprain of thoracic, right sprain of knee & leg. **Recommendations:** 1. No physical therapy at this time. 2. Medication: Naproxyn , Flexeril 3. The appeal with Sedgwick was denied; will send patient for FCE, then at next visit send for \_\_. 4. Continue light duty and pain medications. 5. Continue HEP. Formal PT denied. 6. Referral to the FCE for right shoulder, thoracic spine, right knee.

02/12/2015: Follow Up Evaluation. **Subjective:** Patient states she still has pain in shoulder and mid back of 7/10 and knee pain 6/10. **Physical Exam:** Cervical Spine: Full ROM. Side bonding normal. Rotation normal. Flexion normal. Extension normal. Muscle spasms along the paraspinal \_\_\_\_ resolved. Trapezius muscle spasm is noted: none. Tenderness to palpation resolved. Upper extremities: Full ROM vascular intact. Sensation normal. Shoulder: Right: Tenderness anterior remained the same. ROM abduction remained the same. Flexion remained the same 90 degrees. Internal rotation remained the same. External rotation remained the same. Muscle testing improving. Thoracic Spine: Inspection lateral deviation of remained the same. Kyphocle remained the same. ROM flexion normal. Extension normal. Rotation normal. Muscle spasm remained the same. Tenderness remained the same. Knee: Right: Full ROM. Inspection no obvious deformity. ROM flexion returned to normal. Extension returned to normal. **Diagnosis:** Right sprain of neck, Right acromioclavicular sprain, right sprain of thoracic, right sprain of knee and leg. **Recommendations:** 1. No physical therapy 2. Medications: Naproxyn, Flexeril, Tramadol. 3. Will refer for work condition. F/U in 2 weeks. 4. Continue light duty and pain medications. Restrictions per FCE. 5. Referral to work conditioning.

03/03/2015: Letter. After further consideration and discussion, it has been decided that will require 10 days of a Work Conditioning program at 3 hours per day to improve strength, endurance, and range of motion of the Thoracic spine, right shoulder, and right knee to allow her to return to work at a full duty capacity.

06/05/2015: UR. **Rationale for Denial:** The patient is a female who reported an injury on xx/xx/xx. The mechanism of injury was a fall. Her diagnosis was noted to include right sprain of neck, right acromioclavicular joint or ligament sprain, right sprain of the thoracic spine, and right sprain of the knee and leg not elsewhere classified. A functional Capacity Evaluation was performed on 01/28/2015, indicating the patient was participating in a physical demand level of light to medium, lifting up to 30 pounds. The patient was noted to have begun a work hardening program on 04/02/2015. It was noted that the patient had tested below her physical demand level to return to safely to work on full duty. It was noted the patient was currently functioning in the medium work level. Lifting up to 30 pounds and 15 pounds frequent. It was noted that the patient had been in attendance 100% of the program. The patient reported continued difficulties with trunk rotation, squatting, overhead reaching, prolonged standing, prolonged sitting, prolonged walking, stairclimbing, reaching, and grasping. The rationale for an additional 10 days of outpatient medical rehabilitation program was to increase the strength and endurance, increase the flexibility, and increase the patient's physical demand level of her current position of employment. The physical goals for 10 days of the outpatient medical rehabilitation program include, improve lifting from floor to waist level, improve lifting from waist to shoulder level, improve lifting from waist to overhead level, improve waist level up to 20 meters, and carrying from 30 pounds to 45 pounds, improve ability to perform modified Naughton's treadmill test from 4.5 MET to 6.0 MET. Improved ability to perform the 3 minute, 12 inch step from 3.0 MET to 5.0 MET. Improve the ability to perform the work activity of squatting and reaching up to frequent, and improve the ability to perform the work postures of walking on a flat surface from frequent to constant. The physical examination reported hyper lordosis of the cervical spine with anterior carriage of the head. The patient reported a limp with decreased weight bearing on the right. The patient reported her current pain as an 8/10 . It was noted that the patient had completed the maximum number of sessions allowed by the Official Disability Guidelines. The Official Disability Guidelines recommend up to 10 visits

over 4 weeks, equivalent to up to 30 hours for work conditioning physical therapy guidelines. The requested additional 10 visits exceeds guideline recommendation. There were no exceptional factors noted within the physical examination to warrant additional intensive physical therapy beyond the guideline recommendation. Given the above, the request is non-certified.

06/16/2015: UR. **Rationale for Denial:** The worker has been provided the opportunity to participate in traditional physical therapy followed by a work conditioning program with limited functional recovery noted in terms of physical performance. The worker is now being recommended participation in yet another physical rehabilitation program within the same clinical setting, this time a multidisciplinary medical rehabilitation program that is not typically utilized as a return to work program for musculoskeletal injuries; rather the OMRP is more commonly applied to those with complex medical disorders that require services not usually available in work conditioning programs or work hardening programs. The medical necessity for the transition to another return to work program is not supported by the clinical guidelines. The prior non-certification recommendation is upheld even though the rationale is different noting the prior response to have been more specific to continuation of a work conditioning program.

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

Denial of 10 sessions of a rehabilitation program 4 hours a day, 5 days a week for 2 weeks is UPHELD/AGREED UPON since there is lack of clinical information. It is unclear as to the type of rehabilitation program already completed since previous 10 visits are referred to as both work conditioning (a single discipline) and work hardening (a multi-discipline program). There is also question as to the number of hours and over what time frame/duration that this program took place. If the previous visits were considered "work conditioning," then certainly request for an additional 10 sessions = 40 hours, exceeds ODG recommended number of hours (30 over 4 weeks). And furthermore, there is documentation of NO functional improvement with an FCE dated 1/28/15 noting lifting capability of 30 lbs. compared to training numbers after 10 sessions on 4/2/15 of lifting 30 lb. occasionally and 15 lb. frequently - a manifestation that "work conditioning" was the inappropriate level of rehabilitation in the first place, conceding that functional rehabilitation is NOT a step-wise process from one program to next until exhausted, but rather, the placement of the most appropriate level of rehabilitation to maximize participation and benefit. If the previous levels were considered "work hardening," and/or the current requested "rehabilitation program" is "work hardening"/multidisciplinary, multiple ODG criteria for such an aggressive program are NOT met based upon the submitted clinical medical information. Other than reported functional "goal" from 30 lb. carry to 45 lb. carry, there is no submitted required job demands or even the type of work to return to. There is also no mention of whether there is even a job to return to, nor whether light duty work status had been or continues to be accommodated, and whether the claimant had continued to and continues to work part day while attending rehab part day. Therefore there is no required work demands to which to compare current training numbers, nor a recent Functional Capacity Evaluation or Physical Performance Evaluation in order to demonstrate continued "functional deficits," thereby requiring additional functional rehabilitation. And if there is no job to return to, there is question as to consideration of vocational counseling.

Furthermore, there is no psychological/behavioral evaluation/screen to rule out or establish psychosocial barriers to recovery and demonstrated necessity for multidisciplinary rehabilitation program. There is also question as any pending invasive procedures. There is also question as to current medications, particularly any habituating medications which require weaning. Therefore, medical necessity for Outpatient Medical Rehab Program (10 Sessions (4 hrs a day for 5 days a week for 2 weeks) has NOT been established.

### 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.

Suggested 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)