

# Icon Medical Solutions, Inc.

11815 CR 452  
Lindale, TX 75771  
P 903.749.4272  
F 888.663.6614

## Notice of Independent Review Decision

**DATE:** March 10, 2015

**IRO CASE #:**

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

Work Conditioning x 40 hours

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

The reviewer is certified by the American Board of Physical Medicine and Rehabilitation 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 injured her back when she lifted a shelf wrong while working on xx/xx/xx.

10/25/14: The claimant was evaluated for low back pain. She reported numbness and tingling to the left lower extremity. On exam, she had moderate lumbar tenderness and no neurological deficits. Lumbar x-ray showed no evidence of fracture or dislocation of the lumbosacral spine. She was diagnosed with acute lower back strain/pain and acute muscle spasm. She was prescribed Robaxin 750 #84, Tylenol No. 3 #24. She was given educational materials regarding lumbosacral strain and back pain.

11/20/14: The claimant was evaluated for left-sided low back pain rated 8/10. The plan was to get ER x-ray report, start physical therapy, and continue modified duty. She was prescribed Skelaxin 800 mg #15 and Ultram 50 mg #40. Her work was restrictions included no bending, stooping, or twisting, no driving/operating heavy equipment, no working at heights or on scaffolding, and no lifting/carrying objects more than 5 pounds.

12/01/14: The claimant was evaluated. It was noted that despite physical therapy, modified duty, and medications, she continued with low back pain with stiffness and radiculitis to the posterior right thigh. She denied bowel or bladder dysfunction and bilateral motor leg weakness. The pain was constant, at night time, and when going to bed. Aggravating factors included bending, moving around, pulling, and pushing. Alleviating factors included not moving. She stated that she was working "about a week ago" and felt a pop where her back was initially hurting. She felt a warming sensation in the back radiating down the right leg when moving around a lot. She rated her pain as 8/10. Her medications included acetaminophen/hydrocodone 325/5 mg and methocarbamol 750 mg. She was working fulltime as a manual laborer at a moderately demanding position. On exam, the back showed TTP to the bilateral L-spine. Range of motion was limited and with pain and spasm to the right buttock and right posterior spine. Heel and toe walk were normal. Reflexes were symmetric at 2+/4+. SLR negative bilaterally. Neurological exam showed normal reflexes and sensation. She was diagnosed with lumbosacral sprain, spasm of muscle, and backache unspecified. She was to continue with meds, continue physical therapy with adding a TENS unit, get MRI of the lumbar spine, and continue with modified duty.

12/08/14: MRI of the lumbar spine. IMPRESSION: Mild degenerative disc changes at L3-L4 with minimal anterior and posterior annular bulging and mild disc desiccation. Minimal degenerative disc desiccation is seen to the discs from T11-T12 through L2-L3 and L4-L5 and L5-S1. Mild foraminal encroachment is seen on the left at L2-L3 and L3-L4 with minimal foraminal encroachment bilaterally at L4-L5. Mild facet arthropathy is seen at L3-L4 and L4-L5 with minimal facet arthropathy at L5-S1. No vertebral body compression fracture is seen. Incidental finding of a 1.2 cm left renal cyst is seen.

12/16/14: The claimant was evaluated. She related persistent low back pain with active movement and with prolonged sitting. She denied bowel/bladder symptoms, bilateral motor leg weakness. She was to continue with physical therapy, get FCE, and continue modified duty.

01/08/15: The claimant was evaluated. She was still having pain in the low back that seemed to be radiating down both legs. She stated that she was not doing physical therapy as she was waiting to have more approved. She also stated that she had not gotten an SI belt yet, as several places did not accept worker's compensation. She stated that her pain medicine was what helped her to keep going. She rated her pain as 8/10. On exam, she had low back tenderness. Range of motion was limited with pain. Heel and toe walk were normal. Reflexes were symmetrical. SLR negative bilaterally. She was to continue with work restrictions and follow up on 01/27/15. She was prescribed tramadol and Skelaxin.

01/16/15: A Functional Capacity Evaluation concluded that the claimant did not demonstrate the physical capacity needed to reasonably complete her job tasks

and was not returned to full work duties. She best qualified for sedentary work with modifications.

01/27/15: The claimant was evaluated. It was noted that she stated not much had changed. No transcribed report was submitted for review. The treatment plan was to start work hardening program, continue modified duty, and continue with prescription meds.

02/04/15: UR. RATIONALE: The guidelines recommend 10 visits over 4 weeks, equivalent to up to 30 hours. The requested 40 hours exceeded the guidelines recommendation and not certified.

02/12/15: UR. RATIONALE: The patient underwent a Functional Capacity Evaluation on 01/16/15, where it was indicated that the patient qualified for sedentary work with modifications. The written job description was requested; however, it was not received at the time of the report. Case management documentation indicated that the patient was certified for 6 sessions of physical therapy since the injury. The ODG indicate that work conditioning is an additional series of intensive physical therapy that is required beyond a normal course of physical therapy. Typically more intense and lasts for 2-3 times as long. Maximum duration is 30 hours equivalent. This request was previously denied as the request for 40 hours exceeds guideline recommendations. There was no additional documentation submitted to support the request. There were no physician notes with objective findings submitted for review. As such, the request for appeal work conditioning x 40 hours is not certified.

02/17/15: The claimant was evaluated. She stated there was no change. She stated when standing on feet and first thing in the morning, the pain increased. She had a sharp pain that increased down the left leg. She stating when "sitting on a potty," bilateral feet go numb. Her pain rating was 8/10. She was taking tramadol and Skelaxin. No exam was submitted for review. She was to continue on modified duty and start work hardening program and follow up on 03/10/15.

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

The previous adverse decisions are upheld given that the request exceeds ODG recommended number of hours of this level of rehabilitation; there is question as to the number of basic PT visits completed, the progress with these visits and instruction in/compliance with a home exercise program; there is no documented job requirements to which to compare to the sedentary capabilities on the FCE, nor a PDL goal to ascribe to, nor whether there is even a job to return to upon completion of the requested work conditioning program; and with continued very high levels of pain (persistently 8/10) and continuance of habituating medications (Tramadol and Skelaxin) there is question as to significant barriers to recovery which invalidate work conditioning as the appropriate rehabilitation level for this case at this point in time. Therefore, the request for Work Conditioning x 40 hours is not medically necessary.

ODG:

<p>Work conditioning, work hardening</p>	<p><b>Criteria for admission to a Work Hardening (WH) Program:</b></p> <p>(1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation:</i> 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.</p> <p>(3) <i>Job demands:</i> 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).</p> <p>(4) <i>Functional capacity evaluations (FCEs):</i> 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.</p> <p>(5) <i>Previous PT:</i> 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.</p> <p>(6) <i>Rule out surgery:</i> 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).</p> <p>(7) <i>Healing:</i> Physical and medical recovery sufficient to allow for</p>
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	<p>progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.</p> <p>(8) <i>Other contraindications:</i> 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.</p> <p>(9) <i>RTW plan:</i> 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.</p> <p>(10) <i>Drug problems:</i> 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.</p> <p>(11) <i>Program documentation:</i> 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.</p> <p>(12) <i>Further mental health evaluation:</i> 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.</p> <p>(13) <i>Supervision:</i> 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.</p> <p>(14) <i>Trial:</i> 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.</p> <p>(15) <i>Concurrently working:</i> 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.</p> <p>(16) <i>Conferences:</i> There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and</p>
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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](#)).

Exceptions to the 2-year post-injury cap may be made for patients with injuries that have required long-term medical care; i.e., extensive burns, diagnoses requiring multiple surgical procedures, or recent (within 6 months) completion of the last surgery, for patients who do not have the psychological barriers to return to work that would qualify them for a CPM program. ([L&I, 2013](#))

(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

	<p>significant psychosocial, drug or attitudinal barriers to recovery not addressed by these programs). See also <a href="#">Physical therapy</a> 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.</p> <p><i>Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.</i></p>
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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)