CASEREVIEW

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September 2, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
80 Hours of Work Hardening

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

This physician is Board Certified in 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 was injured. She was working and while stopped at a stop sign, was struck from behind, resulting in complaints of neck and back pain. According the Peer Review, the claimant was initially evaluated, where she was diagnosed with neck pain with right shoulder/arm radiculopathy and lower back pain with right leg radiculopathy. She was prescribed a Medrol dose pack, Norco, Flexeril and pain cream. X-rays of the cervical spine revealed mild anterior spurring and mild bilateral facet arthropathy at C4/5 and C5/6. X-rays of the lumbar spine revealed a levoscoliosis at L3/4 with a Cobb angle measuring 3 degrees and mild bilateral facet arthropathy at L4/5 and L5/S1. then ordered MRIs of the cervical and lumbar spine. On April 9, 2015, a PLN-II accepted compensability for a low back and neck strain only.

On April 20, 2015, the claimant presented to determine if mental health treatment would be appropriate. Current medications: Flexeril and Hydrocodone. Current Complaints: Primary location of her pain is in her neck and lower back. The pain seems to radiate from her lower back down her right leg t the sole of her foot. Pain is described as constant, burning, sharp, stabbing, aching, numbness, and tingling sensation. Pain rated a 7/10 on an average day. Activities which increase her pain include: prolonged standing, sitting, and walking; bending; twisting or turning her upper body; lifting; driving; and other basic life tasks or chores around the home. She reports sleeping only around four hours at night due to several disruptions from both the pain and her mind racing. She reports that she is very weak and cannot perform basic activities in her life. BDI-II score of 24, within the moderate range. BAI score of 20, within the moderate range. Impression: The interviewer feels that there is a strong indication that the patient is experiencing pain that is creating interference in her life. It appears as

though she is having adjustment problems of depression and anxiety which are secondary to her work-related injury. DSM-IV: Axis I: Pain Disorder with Both Psychological Factors and a General Medical Condition, acute. Axis II: Deferred. Axis III: 847.0 & 847.2. Axis IV: Pain, job concerns, financial struggles, multiple social losses, and problems with family. Axis V: GAF=60. Recommendations: Patient should participate in a work hardening program in order to better facilitate her reconditioning and return to work.

On May 11, 2015, the claimant underwent an FCE. Overall level of effort by the claimant during testing was deemed reliable. The result of the FCE revealed that she is unable to safely and dependably return to the usual and customary duties per the job analysis. Overall she demonstrated the ability to safely and dependably perform at a sedentary physical demand level.

On May 27, 2015, according to the Pre-Authorization letter, the claimant has completed active rehabilitation and reached a plateau in her recovery. It was reported that she past treatment had included prescription medication, active physical rehabilitation and physical therapeutic modalities. It was reported the claimant had verbalized anxiety regarding whether she will be able to perform her job but was eager to try. 10 sessions of work hardening were requested.

On June 2, 2015, UR. Rationale for Denial: The case has been reviewed and there are inconsistencies in the functional capacity evaluation. There is nothing populating the 5 position grip test graph which is used to judge effort. The Rapid Exchange Grip test for the right hand exceeded 100% of the five position grip maximum indicating the patient may not be providing maximum voluntary effort. The neck flexion and extension times for the muscle testing were highly variable as were right shoulder flexion, right elbow flexion and extension, right hip extension, right ankle flexion, and right foot dorsiflexion and inversion. The rater felt that the overall level of effort was reliable, but the above calls that in to question. The request does not meet ODG recommendations.

On June 15, 2015, On May 11, 2015, the claimant underwent an FCE. Overall level of effort by the claimant during testing was deemed reliable. The result of the FCE revealed that she is unable to safely and dependably return to the usual and customary duties per the job analysis. Overall she demonstrated the ability to safely and dependably perform at a sedentary physical demand level.

On June 26, 2015, UR. Rationale for Denial: There are several inconsistencies on FCE. Also, there is no specific need for psych or voc to support his work hardening multidiscipline program request that is accordingly not consistent with ODG.

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

Determination: denial of 80 hours of work hardening is UPHELD/AGREED UPON since there is lack of clinical information. There is question regarding the number of previous basic Physical Therapy visits, progress with these visits and compliance with a home exercise program. There is question regarding whether invasive procedures have been ruled out prior to progressing to functional rehabilitation. There is question regarding the current quantity of consumed habituating medication, particularly Flexeril and Hydrocodone and the specific goals of the weaning process off these medications. Given high psychometric parameters of depression and anxiety, there is question regarding consideration of psychotropic medication to stabilize mood prior to, and to maximize participation in, such an aggressive functional rehabilitation program. There is question regarding any individual counseling sessions regarding chronic pain and associated psychological features. There is question as to current activity/work status and whether there is a job to return to with the employer of injury. Therefore, the request for 80 hours of work hardening does not meet ODG criteria and is 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 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, seeChronic 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 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)**