Professional Associates P. O. Box 1238 Sanger, Texas 76266 Phone: 877-738-4391 Fax: 877-738-4395

08/15/18

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Ten sessions of work hardening for the cervical, thoracolumbar, and left knee

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

Board Certified in Orthopedic Surgery
Fellow of the American Academy of Orthopedic Surgeons
Fellow of the American Association of Orthopedic Surgeons
Diplomate of the of the American Board of Orthopedic Surgery

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

X Upheld (Agree)

☐ Overturned (Disagree)

☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

Ten sessions of wok hardening for the cervical, thoracolumbar, and left knee – Upheld

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient underwent a bilateral SI joint injection on XXXX. XXXX then attended therapy for 4 sessions in XXXX based on the documentation provided. XXXX was then reevaluated on XXXX. According to this report, XXXX attended 20 sessions of therapy, but XXXX had mostly left sided back pain radiated to the left lower extremity with weakness. ROM was 3-100 degrees on XXXX and currently 3-115 degrees. In the lumbar spine flexion was 50 degrees on both days and extension was 20 degrees. Lateral flexion had improved from 20 degrees to 25 degrees bilaterally. Strength was 3-3+/5 in the lower extremities. Therapy was recommended 3 times a week for 4 weeks, which the patient attended from XXXX for 11 sessions. On XXXX, a request

was submitted for an FCE and a mental health evaluation. An FCE was then obtained on XXXX and revealed XXXX was currently on XXXX. XXXX was not currently working and XXXX had left knee surgery on XXXX. Lumbar ROM was decreased and XXXX multiple studies were noted. XXXX was currently functioning in the sedentary PDL and XXXX preinjury PDL was light. The patient then underwent an initial mental health evaluation on XXXX. XXXX had been recommended for 10 sessions of work hardening and /XXXX rated XXXX low back and left knee pain at XXXX scored XXXX on BDI and XXXX on BAI. Ten sessions of a work hardening program were recommended at that time. XXXX followed-up with the patient for XXXX. XXXX had back and left leg pain daily and was taking XXXX with partial relief. XXXX had weakness, a burning sensation, and cramping of the left leg. XXXX had back surgery at age XXXX and a hysterectomy, bladder lift, and gallbladder surgery. XXXX was refilled and XXXX was referred for work hardening. A referral was provided at that time. On XXXX, XXXX. provided an adverse determination for XXXX for the requested 10 sessions of work hardening. Another preauthorization request was submitted on XXXX for 10 sessions of work hardening. On XXXX, also on behalf of XXXX, provided another adverse determination for the requested 10 sessions of work hardening for cervical, thoracolumbar, and left knee.

ANALYSIS AND EXPLANATION OF THE DECISION IN/CLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The patient is a XXXX who was reported to have sustained a work-related injury on XXXX. XXXX is now over five years status post injury with an unclear diagnosis at best. The physical therapy notes reviewed are consistently handwritten, illegible, and contain little objective documented parameters. The patient has not returned to work in any capacity for five plus years, yet a work-hardening program has been requested. The medical records clearly documented significant psychosocial issues, which have not been addressed, which is a requirement for the program. In addition, there is no defined plan for return to work, another requirement for consideration of the program. The FCE, which was performed on XXXX, is invalid since that most of the testing parameters were not even attempted. There are no objective physical deficits documented in the records reviewed to preclude this testing. The request was non-certified on initial review by XXXX. XXXX non-certification was upheld on appeal/reconsideration by XXXX. Both reviewers completed a peer-to-peer with XXXX. and both reviewers noted that their opinions were based on the evidence based Official Disability Guidelines (ODG).

The criteria for admission to a work hardening program as recommended by the evidence based ODG includes the following: 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 a 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 medication, history of previous injury, current employability, future employability, and time off work. B) Review of systems to include other non-related medical conditions. C) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, or a physical and/or occupational therapist and/or assistant. 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 would 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, 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 noted by the work injury and associated deficits. 4) A valid FCE is recommended prior to admission to a work hardening program with preference for assessments tailored to a specific task or job. This evaluation should performed, administered, and interpreted by a licensed medical professional. The result should indicate consistency with maximal effort and demonstrate capacities below an employer-verified physical demand analysis. Inconsistencies and/or indications that the patient has performed below maximum effort should be addressed prior to treatment in these programs. 5) Previous physical therapy. 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 surgery, injections, or other treatments that 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 four 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) Return-to-work plan. A specified, 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 the employee. The work goal to which the employee should return must have demands that exceed the patient's current validated abilities. 10) Direct problem. There should be documentation that the patient's medication regimen will not prohibit him from returning to work, either at the 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, result, and 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 improvement and the plans to undertake this improvement. The assessment should indicate that program providers are familiar with the expectation 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 upon 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 evaluation. They should design a treatment plan and be in charge of changes required. They also are in charge of the direction of the staff. 14) Trial. Treatment is not supported for longer than one to two weeks without evidence of patient compliance and demonstration of 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 has been released to work with specific restrictions and may participate in the program while concurrently working in a restricted capacity, but the total number of daily hours should not exceed eight 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) Vocational rehabilitation. Vocational consultation should be available if there is indication of a significant barrier. This should be required if the patient has no job to return to. 18) Postinjury cap. The worker must be no more than two years past date of injury. Workers who have not returned to work by two years postinjury generally do not improve from intensive work hardening programs. If the worker is greater than one year postinjury, a comprehensive multidisciplinary program may be warranted if there is clinical suggestion of psychological barriers to recovery, but these more complex programs may also be justified as early as eight to twelve weeks. 19) Program timelines. These approaches are highly variably in intensity, frequency, and duration. American Physical Therapy Association, American Occupational Therapy Association, and utilization of guidelines for individual jurisdictions may be inconsistent. In general, the recommendations for use of such programs would fall within the following ranges. These approaches are necessarily intensive with highly variable treatment days ranging from four to eight hours with treatment ranging from three to five visits per week. The entirety of this treatment should not exceed twenty full-day visits over four weeks, or no more than 160 hours aligned for part-day sessions if required by part-time work over a longer number of weeks. A reassessment after one to two weeks should be made to determine whether completion of the chosen program 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. This should be evidence documented of the clinical and functional status, recommendations for return to work, and recommendations for follow-up services. The patient's attendance and progress should be documented including the reasons 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 that the patient is unable to participate due to underlying medical conditions including substance abuse dependence. 21) Repetition upon completion of rehabilitation program, work conditioning, work hardening, outpatient medical rehabilitation, or chronic pain/functional restoration program. Neither reenrollment in nor repetition in the same or similar rehabilitation program is medically warranted for the same condition or injury.

The patient is now five plus years status post injury and has not returned to work in any capacity. The medical documentation reviewed clearly demonstrates significant psychosocial issues which

have not been addressed as discussed above. In addition, there is no defined job to return to as documented in the peer-to-peers with P.A. XX by both the previous peer reviewers. Therefore, the request for 10 sessions of a work hardening program for cervical, thoracolumbar, and left knee is not medically necessary, reasonably related, or supported by the evidence based ODG and the previous adverse determinations should be upheld at this time.

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**

X **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**

☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

☐ **MILLIMAN CARE GUIDELINES**

X **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) on BDI and**

☐ **OTHER EVIDENCE BASED, SCIENTIFIC/ALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**