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Description of the service or services in dispute:
CPT 97545 and 97546 - 80 hours of Work Hardening Program

Description of the qualifications for each physician or other health care provider who reviewed the decision:
Licensed Chiropractor

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

☐ Overturned (Disagree)

☑ Upheld (Agree)

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

Patient Clinical History (Summary)
XXXX is a XXXX year-old XXXX who was diagnosed with unspecified tear of unspecified meniscus, current injury, left knee, subsequent encounter (S83.207D). XXXX sustained a work-related injury on XXXX; XXXX and struck left knee XXXX. The associated diagnoses included unspecified internal derangement of the left knee, chondromalacia patellae of the left knee and contusion of the left knee, subsequent encounter. The request was for work hardening.

Behavioral evaluation on XXXX showed Beck Depression Inventory (BDI) 26, Beck Anxiety Inventory (BAI) 42, and maxed Fear-Avoidance Beliefs Questionnaire (FABQ) scores. Functional capacity evaluation (FCE) on XXXX was reported to show physical ability at the light demand level.

On XXXX, XXXX was seen by XXXX for left knee pain. The pain was located in the left anterior, medial and lateral position. The pain was described as aching, stabbing, sharp, occasional and unchanged in nature. The aggravating factors included walking, bending / squatting, range of motion, weightbearing and cold weather. The pain was relieved by heat, rest, physical therapy / occupational therapy. The left knee examination revealed tenderness of the medial joint line and the lateral joint line. The soft tissues were diffusely tender to palpation throughout the knee. The active range of motion was limited. The passive range of motion was also limited with pain elicited by motion. The muscle strength was noted as 4/5 with flexion and 4/5 with extension.

An MRI of the left knee dated XXXX showed horizontal grade 2 signal in the posterior horn of the medial meniscus that extended to or very close to the inferior articular surface near the free edge. There was also peripheral grade 2 signal and mild extrusion of the body of the medial meniscus, which could suggest injury to the coronary ligaments of the medial meniscus. There was also a small intraosseous cyst with mild surrounding bone marrow edema adjacent to the posterior root of the medial meniscus. There was mild scarring of the proximal medial collateral ligament. Mild chondromalacia was noted along the medial and

lateral patellar facets. There was soft tissue edema in the superior aspect of Hoffa's fat pad. A small joint effusion was also noted. An undated x-ray showed medial collateral ligament avulsion injury. The joint spaces were maintained.

The treatment to date included medications (XX, XX), physical therapy, and a XX injection. The physical therapy helped significantly and temporarily.

Per a utilization review decision letter dated XXXX, the requested service was denied by XXXX, with the following rationale: "I spoke with XXXX on XXXX. XXXX stated that the claimant has attended 12 sessions of physical therapy. The claimant has seen an orthopedist, XXXX, and surgery was not recommended. The claimant was then referred to them for consideration of a return-to-work program. XXXX stated that XXXX would fax XXXX report for review. I received a fax consisting of an office note dated XXXX, XXXX. This note was not complete, and it did not include the assessment or treatment plan. Recommend adverse determination. There is inadequate evidence that the claimant has completed all lower levels of care. There are conflicting reports regarding the number of therapy sessions attended. There is inadequate documentation that active treatment is not under consideration. Lastly, it is unclear why the claimant would need a tertiary rehab program for a job that requires lifting 30 pounds on an occasional basis."

Per a reconsideration review decision letter dated XXXX, the initial level adverse determination was upheld by XXXX with the following rationale: "This appeal level request does not address the issues that the initial level reviewer documented. The patient is alleged to have a meniscal tear. If that is the case, there needs to be documentation from the treating orthopedist that knee surgery has been ruled out. If there is no meniscal tear than there needs to be documentation of the currently ongoing occupationally derived knee pathology that reasonably explains and accounts for the patient's alleged disability. Lastly, the patient was injured while working for XXXX. This is a XXXX. There needs to be employer-verified documentation of the RTW PDL, and there also needs to be documentation that there is no job available that the patient can meet with XXXX current functional abilities per FCE. It is unclear why the claimant would need a tertiary rehab program for a job that requires lifting 30 lbs on an occasional basis, especially since the patient is documented as having been terminated from XXXX. Thus, there is no identifiable goal to ´harden´ the patient to."

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

Based on the clinical information provided, the request for CPT 97545 and 97546 - 80 hours of Work Hardening Program is not recommended as medically necessary and the previous denials are upheld. The initial request was non-certified noting that the claimant has attended 12 sessions of physical therapy. The claimant has seen an orthopedist, XXXX, and surgery was not recommended. The claimant was then referred to them for consideration of a return-to-work program. XXXX stated that XXXX would fax XXXX report for review. I received a fax consisting of an office note dated XXXX, XXXX. This note was not complete, and it did not include the assessment or treatment plan. Recommend adverse determination. There is inadequate evidence that the claimant has completed all lower levels of care. There are conflicting reports regarding the number of therapy sessions attended. There is inadequate documentation that active treatment is not under consideration. Lastly, it is unclear why the claimant would need a tertiary rehab program for a job that requires lifting 30 pounds on an occasional basis. The denial was upheld on appeal noting that appeal level request does not address the issues that the initial level reviewer documented. The patient is alleged to have a meniscal tear. If that is the case, there needs to be documentation from the treating orthopedist that knee surgery has been ruled out. If there is no meniscal tear than there needs to be documentation of the currently ongoing occupationally derived knee pathology that reasonably explains and accounts for the patient's alleged disability. Lastly, the patient was injured while working for XXXX. This is a XXXX. There needs to be employer-verified

documentation of the RTW PDL, and there also needs to be documentation that there is no job available that the patient can meet with XXXX current functional abilities per FCE. It is unclear why the claimant would need a tertiary rehab program for a job that requires lifting 30 lbs on an occasional basis, especially since the patient is documented as having been terminated from XXXX. Thus, there is no identifiable goal to ´harden´ the patient to. There is insufficient information to support a change in determination, and the previous non-certification is upheld. Per peer review report dated XXXX, the extent of injury is a left knee strain. Proper treatment for the compensable injury includes 6 to 8 weeks of conservative treatment measures such as rest, ice, compression, elevation, over-the-counter analgesics and non-steroidal anti-inflammatory drugs, activity modification, home exercise, and/or physical therapy of up to 12 visits. The issues raised by the initial denials have not been adequately addressed. Therefore, medical necessity is not established in accordance with current evidence based guidelines.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um knowledgebase
- ☐ AHRQ-Agency for Healthcare Research and Quality Guidelines DWC-Division of Workers
- ☐ Compensation Policies and Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical standards
- ☐ Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment Guidelines
  Knee and Leg Chapter updated

Work conditioning, work hardening
-Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. (Schonstein-Cochrane, 2003)

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 is recommended prior to admission to a Work Hardening (WH) program, with preference for assessments tailored to a specific task or job. This evaluation 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 oversee the 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) Vocational 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. Pre-screening for WC with an FCE is not recommended due to inadequate evidence of any benefit. See Functional capacity evaluation.

Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. (Karjalainen, 2003) Work Conditioning should restore the client's physical capacity and function. Work Hardening should be work simulation and not just therapeutic exercise, plus there should also be psychological support. Work Hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work Hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. (CARF, 2006) (Washington, 2006) The need for work hardening is less clear for workers in sedentary or light demand work, since on the job conditioning could be equally effective, and an examination should demonstrate a gap between the current level of functional capacity and an achievable level of required job demands. As with all intensive rehab programs, measurable functional improvement should occur after initial use of WH. It is not recommended that patients go from work conditioning to work hardening to chronic pain programs, repeating many of the same treatments without clear evidence of benefit. (Schonstein-Cochrane, 2008)

- ☐ Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and 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)