

MEDICAL CONTESTED CASE HEARING NO. 14014

**DECISION AND ORDER**

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and Rules of the Division of Workers' Compensation adopted thereunder.

**ISSUES**

A contested case hearing was held on October 8, 2013 to decide the following disputed issue:

1. Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to a total of 80 hours, 10 units initial work hardening, 60 units additional hours of work hardening for the compensable injury of (Date of Injury)?

**PARTIES PRESENT**

Petitioner, JT, D.C., appeared without representation. Respondent/Carrier appeared and was represented by JS, attorney. Claimant waived her appearance.

**BACKGROUND INFORMATION**

The Claimant's healthcare provider, JT, D.C., recommended that the Claimant undergo 10 units of an initial work hardening program followed by 60 units of additional work hardening for a total of 80 hours (a unit may be comprised of multiple hours) for the compensable right shoulder injury. His request was denied by the Carrier and he filed a request for review, which was undertaken by a utilization review agent (URA). The URA denied the request citing that no documentation was presented of a functional capacity evaluation (FCE) having been undertaken, that there was no behavioral health assessment undertaken, that there was a mismatch between the work requirements and the current capabilities of the Claimant and that there was no intent shown that the Claimant would return to the workforce. Petitioner pointed out to the URA the documentation which met the criteria that was cited for the reasoning for the denial. Petitioner requested a reconsideration of the URA's denial and a second URA reviewed the request. This URA denied the request citing that the Claimant was over 2 years status post-injury and that there was no description outlining the specific duties that would require the Claimant to lift at a medium physical demand level as a teacher. Over a peer-to-peer telephone call, Petitioner noted that due to the denial of the claim treatment had been delayed; the Claimant had been unable to seek appropriate treatment and had become seriously deconditioned. He noted that he had recommended physical therapy, which ended close to 2 years post-injury, that this had considerably helped the Claimant's physical condition and that the 2 year benchmark was not intended as a set rule. He provided an example of a situation where ongoing treatment that was

beneficial would be cut off simply because it came at the 2-year anniversary of the date of injury. Petitioner pointed to his medical records that reflected that the Claimant's FCE had tested at a sedentary functional capacity level that the Claimant had been a school teacher when she sustained her injury, that the Claimant had since retired and was returning to the field of nursing and this field required a medium level lifting capacity. The request was then again appealed and was reviewed by an IRO. The IRO denied the request and did not cite the previously cited reasoning for the denial. Instead, the IRO cited only the initial criteria for admission to a work hardening program, which requires that the program be recommended by a physician or nurse case manager, and a prescription be provided. As a result, Petitioner disputed the IRO's decision and requested a contested case hearing.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines in making decisions about the care of individual patients. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the ODG, and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308 (s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are (sic) considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence.

The ODG provides the following criteria for assessing the medical necessity of the health care at issue:

**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 (sic) 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). 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.

As set out in the listed criteria, the initial criterion is entitled “prescription”. Petitioner presented his testimony wherein he pointed to his medical records wherein he recommended the requested work hardening program on multiple reports, cited all of his reasoning for the request and signed his reports. He noted that he had provided those reports, which were tantamount to his recommendation/prescription of the program to the URAs and the IRO in this case. Petitioner persuasively argued that his reports were even more detailed than a prescription form, that in his field of practice, a recommendation is synonymous with a prescription and that, his recommendation for the work hardening program was equivalent to a prescription for that program. In the Petitioner’s field of practice as a chiropractor it is well known and, as conceded by Petitioner, that chiropractors are unable to prescribe medication. It is, however, a generally accepted standard of practice that is generally recognized in the medical community that

chiropractors are able to recommend treatment programs and, more specifically, it is within their ability to prescribe or recommend work hardening programs as treatment. Through his testimony that the requested treatment was medically necessary for the Claimant's injury and that it met the necessary criteria, Petitioner has presented evidence based-medical evidence to show that the preponderance of the evidence is contrary to the IRO's decision that the Claimant is not entitled to the requested work hardening program.

Even though all the evidence presented was not discussed, it was considered. The Findings of Fact and Conclusions of Law are based on all of the evidence presented.

### **FINDINGS OF FACT**

1. The parties stipulated to the following facts:
  - A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.
  - B. On (Date of Injury), Claimant was the employee of (Employer), Employer and sustained a compensable injury.
  - C. On (Date of Injury), Employer provided workers' compensation insurance via self-insurance.
2. Carrier delivered to Provider a single document stating the true corporate name of Carrier, and the name and street address of Carrier's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.
3. Petitioner presented evidence-based medical evidence to show that the Claimant met the criteria for which the IRO relied upon for denial of the requested total of 80 hours, 10 units initial work hardening, 60 units additional hours of work hardening for the compensable injury of (Date of Injury).
4. A total of 80 hours, 10 units initial work hardening, 60 units additional hours of work hardening is health care reasonably required for the compensable injury of (Date of Injury).

### **CONCLUSIONS OF LAW**

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.
2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that a total of 80 hours, 10 units initial work hardening, 60 units additional hours of work hardening is not health care reasonably required for the compensable injury of (Date of Injury).

### **DECISION**

Claimant is entitled to a total of 80 hours, 10 units initial work hardening, 60 units additional hours of work hardening for the compensable injury of (Date of Injury).

### **ORDER**

Carrier is liable for the benefits at issue in this hearing. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the insurance carrier is **(SELF-INSURED)** and the name and address of its registered agent for service of process is

**SELF-INSURED  
(STREET ADDRESS)  
(CITY), TEXAS (ZIP CODE)**

Signed this 10th day of October, 2013.

Virginia Rodriguez-Gomez  
Hearing Officer