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DATE OF REVIEW: October 15, 2018

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Denial of XX hours of Work Hardening Program

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN WHO REVIEWED THE DECISION
This case was reviewed by a physician who holds a board certification in Physical Medicine and Rehabilitation and is currently licensed and practicing in the State of Texas.

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

☒ Upheld

EMPLOYEE CLINICAL HISTORY [SUMMARY]:
The claimant is a XXXX who was injured on XXXX while at work as a XXXX. XXXX. The claimant was diagnosed with sprain of ligaments of the XX XX, sprain of ligaments of the XX XX, and sprain of ligaments of the XX XX. The claimant had MRI of the XX XX performed on XXXX that revealed "abnormal straightening of the normal XX curvature suggesting muscle spasm. A XX XX within the XX endplate. At the XX/XX level, there is a XX central/subarticular XX protrusion (herniation) measuring X.X- producing effacement of the XX XX on the XX. At the XX/XX level, there is a circumferential XX bulge measuring -, a superimposed XX foraminal XX XX foraminal annular tear producing effacement of the XX XX and moderate XX neural XX XX touching the XX XX nerve root. At the XX/XX level, there is an asymmetric circumferential XX bulge to the XX measuring .X- and a XX foraminal annular tear producing effacement of the XX XX and mild X neural XX XX. At the XX/XX level, there is an asymmetric circumferential XX bulge to the XX measuring - producing effacement of the XX XX and mild XX neural XX XX. At the XX/XX level, there is a XX subarticular XX protrusion (herniation) measuring X.X- and a XX subarticular annular tear producing mild XX of the lateral recess." The MRI of the XX XX dated XXXX revealed "straightening of the XX, suggestive of muscle spasm. No XX vertebral body compression fracture deformity. Mild XX dehydration and central XX space narrowing at XX-XX through XX-XX. XX signal is normal. XX protrusion/herniation at XX-XX produces XX indentation and mildly flattens the ventral XX. XX signal is intensity of the XX herniation to the parent XX suggest an acute/subacute herniation. No central canal XX. XX central X.X- XX protrusion/herniation at XX-XX produces XX XX indentation and minimal XX XX. Adverse correlation for XX XX radiculopathy that would suggest an acute/subacute XX herniation. Central XX protrusion/herniation at XX-XX produces slight midline XX XX indentation without significant neural compromise. Shallow

annular bulge of X- XX-XX and XX-XX producing slight XX XX indentation without significant neural compromise. Reaming XX intervertebral XX levels are unremarkable." The claimant also had functional capacity evaluation performed on XXXX that revealed the claimant demonstrated the ability to safely and dependably perform at a Sedentary physical demand level, which fails to meet the claimant's job requirements. XXXX occupation requires that XXXX is able to safely and dependably perform at a Medium PDL per the job description provided by the patient and/or employer and/or MD Guidelines.

Progress note dated XXXX indicates that the claimant complained of pain in XXXX XX XX and XX XX. The claimant reported pain as sharp and constant in the XX XX, greater on the XX side and radiated down the XX leg. The claimant reported that therapy decreased the pain and helped to restore function. The claimant reported that resting and lying down decreased pain while pushing and lifting increased pain. The claimant was taking XXXX for muscle spasms and XXXX for pain or inflammation. The objective findings on exam included positive for acute lumbosacral/ligamentous injury on the XX during double leg raise, straight leg raise was positive for space occupying lesion at 30 degrees on the XX, and positive for sciatic irritation and/or XX inflammation at 45 degrees on the XX. XX test was positive for coxa injury X. XX was positive for nerve root compression and/or muscular injuries on the XX. Evaluation of the XX XX revealed mild-moderate spasms, mild-moderate + tenderness, mild-moderate tension and mild-moderate decreased range of motion greater on the XX side with pain. Assessment of the XX XX showed mild spasms, mild tenderness and mild tension. Muscle strength was X/X X in the deltoid, biceps, triceps, knee extensors, and knee flexors. Muscle strength was X/X in the hip extensor and hip flexors. Neurological examination XX XX dermatomal distribution showed normal sensory exam. XX, XX, XX, XX, and XX were normal X. The claimant was diagnosed with other intervertebral XX displacement of the XX region, XX radiculopathy, sprain of ligaments of the XX XX, sprain of ligaments of the XX XX, and sprain of ligaments of the XX XX.

On XXXX, the claimant had psychological evaluation by XXXX that revealed it is recommended that XXXX will be treated with work hardening so that the claimant can improve XXXX physical conditioning to the point that XXXX would be able to have XXXX restrictions removed and return to work without impairment. XXXX is a candidate for a work hardening program, which would be adequate for XXXX current needs.

Per the appeal letter dated XXXX from XX, PC, the claimant confirmed that XXXX employer was unable to accommodate restrictions for position as a XXXX and was granted a temporary position pending return to work full duty status. At this time, the claimant has completed 10 sessions of therapy from XXXX and according to the appeal letter dated XXXX the claimant reached a plateau regarding improvement via physical therapy.

Prior UR letter dated XXXX denied the request for coverage of 40 hours of work hardening program because "there was no documentation supporting that the claimant had plateaued during physical therapy. No additional documentation was submitted to support the request. The previous non-certification is supported. According to the guidelines, the use of a work hardening program is recommended when the claimant has plateaued in the recovery with physical therapy. It was noted that the claimant was making progress with physical therapy and that it was helping

improve reported pain and functionality. The guidelines also state that there must be a return to work plan that has been established, communicated and documented between the employer and employee. There was no return to work plan made available for review to support the request. The request for work hardening, XX, XX, 40 hours, ten days is not certified."

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

The claimant is a XXXX who was diagnosed with other intervertebral XX displacement of the XX region, XX radiculopathy, sprain of ligaments of the XX XX, sprain of ligaments of the XX XX, and sprain of ligaments of the XX XX. The request is for coverage of 40 hours of work hardening program for XX and XX XX.

According to the Official Disability Guidelines (ODG), the criteria for admission to a work hardening program require screening documentation. 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, as required to approve this form of treatment.

In this case, the medical records do not reveal documentation of a complete screening evaluation. There is no documentation showing a specific defined return-to-work goal or job plan that needs to be established, communicated and documented between the employer and employee. There is no return to work plan documented for review to support the request in this case.

Therefore, based on Official Disability Guidelines and criteria as well as the clinical documentation stated above, the request of 40 hours of Work Hardening Program is not medically necessary and appropriate.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ODG- Official Disability Guidelines & Treatment Guidelines- Online Version
X X - (updated 7/6/2018)

Work conditioning, work hardening:
Criteria for admission to a Work Hardening (WH) Program:

(X) Prescription: The program has been recommended by a physician or nurse case manager, and a prescription has been provided.
() 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.
(X) 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 oversee the changes required. They are also in charge of direction of the staff.
(14) Trial: Treatment is not supported for longer than X- 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 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 -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-X 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 X- 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 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 (FCE).

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

Appeal Information

You have the XX to appeal this IRO decision by requesting a Texas Department of Insurance, Division of Workers' Compensation (Division) Contested Case Hearing (CCH). A Division CCH can be requested by filing a written appeal with the Division's Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the Division.

Request for or a Division CCH must be in writing and sent to:
Chief Clerk of Proceedings Texas Department of Insurance

Division of Workers' Compensation P. O. Box 17787
Austin, Texas, 78744

For questions regarding the appeals process, please contact the Chief Clerk of Proceedings at 512-804-4075 or 512- 804-4010. You may also contact the Division Field Office nearest you at X-800-252-7031.