

**Core 400 LLC**  
An Independent Review Organization  
2407 S. Congress Avenue, Suite E #308  
Austin, TX 78704  
Phone: (512) 772-2865  
Fax: (512) 551-0630  
Email: [manager@core400.com](mailto:manager@core400.com)

October 17, 2018

*Description of the service or services in dispute:*

*Work hardening 80 hours  
XX*

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

Board Certified 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. The diagnoses were XX-XX XX fracture, XX of XX and XX XX cramp and spasms.

Per a chart note dated XXXX reported decreased dull XX-sided mid to XX XX pain with therapy. XXXX was able to sleep through the night comfortably. Muscle spasm reduction was noted with use of XX (XX) unit. XXXX had completed the XX approved sessions of physical therapy. On examination, XXXX had trouble sitting for the duration of the examination due to pain. There was mild tenderness noted in the thoracolumbar XX with XX noted in the XX. XX test was positive for localized XX pain. AP compression testing was positive for pain.

An MRI of the XX XX performed on XXXX revealed XX and broad-based XX XX herniation at XX-XX, XX-XX, XX-XX and XX-XX measuring XX mm, XX mm, XX mm and XX mm respectively. Limited evaluation of the cervical XX showed multilevel XX XX herniation, most prominent at XX-XX and XX-XX measuring about XX mm at these levels, which flattened the XX aspect of the XX XX at these levels. Limited evaluation of the XX XX revealed a XX XX herniation at XX-XX measuring about XX mm XX, which flattened the XX aspect of the XX sac. At XX-XX, there was also a XX measuring up to XXmm.

Treatment to date included medications, physical therapy and chiropractic care.

Per a utilization review letter dated XXXX, the requested service of work hardening XX times a week for XX weeks (XX hours) – rib, XX XX and XX XX was non-certified. Analysis and clinical basis for conclusion: “The case was reviewed with a requesting provider, XXXX. This provider indicated that the claimant did not have an occupation to return to. A behavioral health assessment report dated XXXX was forwarded for review. The opinions set forth by the requesting provider were very much respected. However, based upon the medical documentation available for review, medical necessity for treatment in a work hardening program was not currently established. A past physical performance evaluation revealed that the claimant was not yet capable of a return to pre-injury work activities. However, recent XX and XX scores were not significantly elevated to support a return to work program in the form of a work hardening program. The submitted clinical documentation does not indicate that there are significant psychological barriers to recovery present that would support a medical necessity for a work hardening program. Consequently, per criteria set forth by the above-noted reference, medical necessity for a work hardening program is not established. Recommended non-certification.”

Per a utilization review letter dated XXXX, the requested service of work hardening XX times a week for XX weeks (XX hours) – rib, XX XX and XX XX was non-certified. Analysis and clinical basis for conclusion: “The XXXX physical performance evaluation determined the patient could perform a sedentary light physical demand level duties, which failed to meet the minimum job requirement for the job XXXX previously held. The XXXX office evaluation reported that the patient had completed 10 approved sessions of physical therapy and was scheduled to undergo XX (XX) testing to determine XXXX pre-physical demand level and a behavioral evaluation to see if XXXX was a candidate for territory return to work program. There was no diagnostic interview with a mental health provider of functional capacity evaluation submitted. I discussed the case with XXXX. No new information was received during peer-to-peer. As such, the request for work hardening (XX hours) for the rib, XX XX and XX XX is non-certified.”

***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 Work hardening XX hours XX - Conditioning and work hardening, first XX hours, XX - Conditioning and work hardening, each additional hour following the first two hours is not recommended as medically necessary, and the previous denials are upheld. The initial request was non-certified noting that the claimant did not have an occupation to return to. A behavioral health assessment report dated XXXX was forwarded for review. The opinions set forth by the requesting provider were very much respected. However, based upon the medical documentation available for review, medical necessity for treatment in a work hardening program was not currently established. A past physical performance evaluation revealed that the claimant was not yet capable of a return to pre-injury work activities. However, recent XX and XX scores were not significantly elevated to support a return to work program in the form of a work hardening program. The submitted clinical documentation does not indicate that there are significant psychological barriers to recovery present that would support a medical necessity for a work hardening program. Consequently, per criteria set forth by the above-noted reference, medical necessity for a work hardening program is not established. The denial was upheld on appeal noting that XXXX physical performance evaluation determined the patient could perform a sedentary light physical

demand level duties, which failed to meet the minimum job requirement for the job XXXX previously held. The XXXX office evaluation reported that the patient had completed 10 approved sessions of physical therapy and was scheduled to undergo functional capacity evaluation (XX) testing to determine XXXX pre-physical demand level and a behavioral evaluation to see if XXXX was a candidate for territory return to work program. There was no diagnostic interview with a mental health provider of functional capacity evaluation submitted. There is insufficient information to support a change in determination, and the previous non-certification is upheld. It is unclear if the patient has a job to return to at this time. The submitted mental health evaluation is over one year old. There is no updated psychological evaluation submitted for review. It is unclear if the patient completed an adequate course of physical therapy with improvement followed by plateau as required by guidelines. 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
- AHRQ-Agency for Healthcare Research and Quality Guidelines
- DWC-Division of Workers Compensation Policies and Guidelines
- European Guidelines for Management of Chronic XXXX 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

XX XX Chapter

Work Hardening: Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker XX to work is with a modified duty RTW program (see the section "ODG Capabilities & Activity Modifications for Restricted Work" in [Work](#)), rather than a work hardening/conditioning program, but when an employer cannot provide this, a work hardening program specific to the work goal may be helpful. The ODG WH criteria are outlined below.

See also [Return to work](#), where the evidence presented for "real" work is far stronger than the evidence for "simulated" work. See also [Exercise](#), where there is strong evidence for all types of exercise, especially progressive physical training including milestones of progress, but a lack of evidence to suggest that the exercise needs to be specific to the job. See [Firefighter return to duty program](#) in the Fitness for Duty Chapter for a program tailored to the unique demands of firefighting. See [Functional capacity evaluation](#) in the Fitness for Duty Chapter.

**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 XX 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 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](#)). 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. Pre-screening for WC with an XX is not recommended due to inadequate evidence of any benefit. See [Functional capacity evaluation \(XX\)](#).

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

Physical conditioning programs that include a cognitive-behavioral approach plus intensive physical training (specific to the job or not) that includes aerobic capacity, muscle strength and endurance, and coordination; are in some way work-related; and are given and supervised by a physical therapy provider or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic XX pain, when compared to usual care. However, there is no evidence of their efficacy for

acute XX pain. These programs should only be utilized for select patients with substantially lower capabilities than their job requires. (Schonstein, 2003) See also Chronic pain programs (functional restoration programs), where there is strong evidence for selective use of programs offering comprehensive interdisciplinary/ multidisciplinary treatment, beyond just work hardening. Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic XX pain. However, specialized XX pain rehabilitation centers are rare and only a few patients can participate in this therapy. It is unclear how to select who will benefit, what combinations are effective in individual cases, and how long treatment is beneficial, and if used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). (Lang, 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. Work conditioning and work hardening are not intended for sequential use. They may be considered in the subacute stage when it appears that exercise therapy alone is not working and a biopsychosocial approach may be needed, but single discipline programs like work conditioning may be less likely to be effective than work hardening or interdisciplinary programs. (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, 2003) Use of Functional Capacity Evaluations (FCEs) to evaluate return-to-work require validated tests.

***Other established guidelines:*** High-quality prospective studies are lacking for Work Conditioning and Work Hardening, but there are consensus guidelines used by providers of these programs. The term "work hardening" was first introduced in the late 1970s (Matheson, 1985), with a description as a "work-oriented treatment program" with an outcome of improvement in productivity. An assessment is necessary, and activities include real or simulated work activities. (Lechner, 1994) The first guidelines for work hardening were introduced in 1986 by the American Occupational Therapy Association Commission on Practice. (AOTA, 1986) In 1988 the Commission for Accreditation of Rehabilitation Facilities (CARF) addressed standards, suggesting that the programs must be "highly structured and goal oriented." Services provided by a single practitioner were excluded from CARF accreditation for work hardening. (CARF, 1988) As CARF accreditation includes extensive administrative and organization standards, the Industrial Rehabilitation Advisory Committee of the American Physical Therapy Association (APTA) developed the Guidelines for Programs in Industrial Rehabilitation. (Helm-Williams, 1993) This was primarily to offer more flexibility. Types of programs in these guidelines are outlined below:

***Single-Discipline Exercise Approaches:*** Approaches or programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, and typically called Work Conditioning (WC). Single-discipline approaches, like WC, may be considered in the subacute stage when it appears that physical rehabilitation alone is not working. For users of ODG, WC amounts to an additional series of intensive physical therapy (PT) visits required beyond a normal course of PT, primarily for exercise training/supervision. It is an intermediate level of nonoperative therapy between acute PT and interdisciplinary/ multidisciplinary programs, according to the number of visits outlined in the WC/PT guidelines, which appear below the ODG WH criteria.

***Interdisciplinary Work-Related Exercise Approaches Adding Psychological Support:*** These approaches, called Work Hardening (WH) programs, feature exercise therapy combined with some elements of psychological support (education, cognitive behavioral therapy, fear avoidance, belief training, stress management, etc.) that deal with mild-to-moderate psychological overlay accompanying the subacute pain/disability, not severe enough to meet criteria for chronic pain management or functional restoration programs. (Hoffman, 2007) See also Chronic pain programs (functional restoration programs). There has been some suggestion that WH should be aimed at individuals who have been out of work for 2-3 months, or who have failed to transition XX to full-duty after a more extended period of time, and that have evidence of more complex psychosocial problems in addition to physical and vocational barriers to

successful return to work. Types of issues that are commonly addressed include anger at employer, fear of injury, fear of return to work, and interpersonal issues with co-workers or supervisors.

- 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)

### **Appeal Information**

You have the right 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 1-800-252-7031.