MEDICAL CONTESTED CASE HEARING NO. 19007

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC). For the reasons discussed herein, the Administrative Law Judge (ALJ) determines that:

> Petitioner/Claimant is not entitled to twenty hours of a work conditioning program for the compensation injury of (Date of Injury).

STATEMENT OF THE CASE

On May 13, 2019, Warren E. Hancock, Jr., a DWC administrative law judge, held a contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the determination of the Independent Review Organization (IRO) that Petitioner/Claimant is not entitled to twenty hours of a work conditioning program for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Petitioner/Claimant appeared and was assisted by EM, ombudsman. Respondent/Insurance Carrier appeared and was represented by NM, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

> For Petitioner/Claimant: Claimant.
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> For Respondent/Insurance Carrier: None.

The following exhibits were admitted into evidence:

> ALJ's Exhibits: ALJ-1 and ALJ-2.
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> Petitioner/Claimant's Exhibits: C-1 through C-5.
>
> Respondent/Insurance Carrier's Exhibits: CR-A through CR-D.

DISCUSSION

Petitioner/Claimant is a (Age)-year-old operator of a grain elevator for Employer of (Years) years tenure. On (Date of Injury) he slipped in a wet area on the floor and fell backwards, catching himself with both arms outstretched behind him. In a previous proceeding, it was determined that the injury extends to and includes a rotator cuff tear, rotator cuff tendinopathy and labral tear, all of the left shoulder; and A/C arthritis with impingement of the left shoulder in addition to Respondent/Insurance Carrier accepted conditions of cervical, thoracic and left shoulder strain/sprains. Petitioner/Claimant underwent surgery on June 28, 2018 by RJ, M.D. for repair of the left shoulder compensable conditions. Dr. J requested a 20-hour work conditioning program between December 26, 2018 and February 24, 2019. This request was denied by Respondent/Insurance Carrier's utilization reviewer VD, D.O. and ST, M.D., an orthopedic surgeon, as reconsideration reviewer. The case was then submitted to the IRO where the records were reviewed by an orthopedic surgeon, who upheld the previous denials.

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. The Commissioner of the DWC 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 DWC has adopted treatment guidelines by DWC Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (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 DWC Rule 133.308 (s), "A decision issued by an IRO is not considered an agency decision and neither the Texas Department of Insurance nor the DWC are 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."

With regard to Work Conditioning/Work Hardening, the ODG states as follows:

> **Work Conditioning, Work Hardening:**
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> Recommended as an option, depending on the availability of quality programs, using the criteria below. The best way to get an injured worker back to work is with a modified duty return-to-work (RTW) program (see the section "ODG Capabilities & Activity Modifications for Restricted Work" in *Work*), rather than a work hardening/work conditioning (WH/WC) program, but when an employer cannot accommodate this, a WH program specific to the work goal can be helpful. WH and WC criteria are outlined below.
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> See also *Return to work*, where the evidence supporting "real" work is much stronger than that for "simulated" work; *Exercise*, where there is strong evidence for all types of exercise, especially progressive physical training including progress milestones, but a lack of evidence that exercise needs to be job specific; *Firefighter return to duty program* for a program tailored to the unique demands of firefighting; *Chronic pain programs (functional restoration programs)*; and *Functional capacity evaluation*.
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> **Criteria for admission to a Work Hardening (WH) program:**
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> (1) *Prescription:* The program has been recommended by a physician or nurse case manager, and a valid prescription has been provided.
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> (2) *Screening Documentation:* Approval of the program should include evidence of a screening evaluation. This multidisciplinary examination should include the following components:
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> (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 from work;
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> (b) Review of systems including other non-work-related medical conditions;
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> (c) Documentation of musculoskeletal, cardiovascular, vocational, motivational, behavioral, and cognitive status by a physician, chiropractor, physical therapist, and/or occupational therapist (and/or assistants);
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> (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 might be appropriately addressed in a multidisciplinary WH program. The testing should also be intensive enough to confirm that there are no psychosocial or significant pain behaviors that should be addressed in other types of programs or that will likely prevent successful participation and return to employment after WH program completion. Development of the patient's program should reflect this assessment.

(3) *Job demands:* A work-related musculoskeletal deficit must be identified with evidence of physical, functional, behavioral, and/or vocational deficits that preclude ability to safely achieve current job demands. These job demands generally fall within the medium or higher demand level (i.e., not clerical/sedentary work). There should 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):* An FCE can be performed, but is not required, at the beginning and upon completion of a WH program, with preference for assessments tailored to a specific task or job. FCEs should be performed, administered, and interpreted by a licensed and properly trained medical professional. Results should indicate a consistent maximal effort, which initially confirms a capacity below an employer-verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below his/her maximal effort should be addressed before beginning the program. When FCEs, which are not indicated for any rehabilitation program screening, are performed in conjunction with WH programs, they are considered to be an integral component of the WH protocol and are not free-standing, separately billable procedures.

(5) *Previous physical therapy:* There is evidence supporting treatment with an adequate trial of active physical rehabilitation, with improvement followed by plateau, without evidence of likely benefit from continuation of previous treatment. Passive physical medicine modalities are not indicated for any of these approaches.

(6) *Rule out surgery:* The patient is not a candidate for surgery, injections, or other treatments 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 3-5 days a week.

(8) *Other contraindications:* There is no evidence of other medical, behavioral, or co-morbid conditions (including 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 the plan was agreed to by the employer and employee. The employee work goal should include 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 the claimant's medication regimen is an issue, other treatment options may be required, such as a program focused on detoxification.

(11) *Program documentation:* The assessment and resulting treatment should be documented and be made available to the employer, insurer, and other providers. There should be documentation of the proposed benefits from the program including functional, vocational, and psychological improvements, as well as the treatment plan to achieve these gains. This assessment should indicate that the program providers are familiar with the expectations of the planned job, including the skills necessary. Evidence of this can 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 indicated. The results of such evaluation may suggest that treatment options other than WH may be required; all mental health screening evaluation information should be clearly documented prior to any 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 all daily activities, participate in initial and final evaluations, design treatment plans and oversee any changes required, and be responsible for all staff direction.

(14) *Trial:* Treatment is not supported for continuation beyond 1-2 weeks without evidence of patient compliance and demonstration of significant gains, documenting both subjective and objective functional improvement. Outcomes

should reflect the goals initially proposed, including those specifically addressing deficits identified during the screening procedure. Progress summaries including physical and functional activities performed during the program should be provided.

(15) *Concurrent working:* A patient who has been released to work with specific restrictions may participate in a WH program while concurrently working in that restricted capacity, but the total number of daily hours should not exceed 8 per day while under treatment.

(16) *Conferences:* There should be reports of routine staff conferencing regarding progress and discharge planning, with documentation of daily treatment activity and response.

(17) *Vocational rehab:* Vocational consultation should be available if this is as a significant barrier, especially if the patient has no job to return to.

(18) *Post-injury cap:* The worker must be no more than 2 years past the date of injury. Workers that have not returned to work by 2 years post-injury generally do not improve from intensive WH programs. If the worker is over 1 year post-injury, a comprehensive multidisciplinary program may be warranted, especially if there is clinical suggestion of psychological barriers to recovery, although these more complex programs may also occasionally be justified as early as 8-12 weeks, see *Chronic pain programs*). Exceptions to the 2-year post-injury cap can be considered for patients with injuries that have required long-term medical care such as extensive burns, multiple surgical procedures, surgery within 6 months, or for patients who do not or no longer have psychological barriers to return to work that would otherwise qualify for a CPM program. (*L&I, 2013*)

(19) *Program timelines:* Approaches are highly variable in intensity, frequency, and duration. APTA, AOTA, and utilization guidelines for individual jurisdictions can be inconsistent. In general, recommendations for WH programs fall within the following ranges: WH programs should be intensive with variable treatment regimens ranging from 4-8 hours, 3-5 visits per week. The entirety of treatment should not exceed 20 full-day visits over 4 weeks, not to exceed 160 hours (allowing partial-day sessions for part-time work, over a longer number of weeks). A reassessment after 1-2 weeks should determine whether completion of the current program is appropriate or whether other alternatives should be considered.

(20) *Discharge documentation:* At the time of discharge, the referral source and other predetermined entities should be notified, including the employer and insurer. There should be clear documentation of the current clinical and

functional status, RTW and follow-up services recommendations. Patient attendance and progress should also be documented, including any reason(s) for termination (non-compliance, declining further treatment, limited potential to benefit) and successful program completion or failure. There should also be documentation if the patient was unable to participate due to underlying medical conditions including substance dependence.

(21) *Repetition:* Upon completion of any rehabilitation program including WH, WC, outpatient medical rehabilitation, or chronic pain/functional restoration programs, neither re-enrollment 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 involves an additional series of intensive physical therapy (PT) sessions required beyond a normal course, primarily for supervised exercise training, and is contraindicated when there are significant psychosocial, drug, or attitudinal barriers to recovery that are not addressed by these programs. WC visits are typically more intensive than regular PT visits, lasting 2 to 3 times longer and focusing on work-required endurance. Consistent with all PT programs, WC participation does not preclude a patient from concurrently working. Pre-screening for WC with an FCE is not recommended due to inadequate evidence of any benefit.

See *Functional capacity evaluation (FCE)* and *Physical therapy* for general PT guidelines.

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

Physical conditioning programs that combine cognitive-behavioral approaches with (job-specific) intensive physical training including aerobic capacity, muscle strength and endurance, and coordination, provided by a physical therapist and/or multidisciplinary team, can be effective in reducing number of sick days for some workers with chronic (not acute) back pain, compared to usual care. These programs are only indicated for select patients who present substantially lower capabilities than their job requires. (*Schonstein, 2003*) Multi-disciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in select patients with chronic back pain. Specialized back pain rehabilitation centers are rare, and selection criteria and ideal length of treatment are unclear, although programs should not exceed 2 weeks without demonstrated subjective and objective gains. (*Lang, 2003*) Work conditioning (WC) should focus on restoration of physical capacity and function. Work hardening (WH) should involve specific work simulation, not only using therapeutic exercise but

also through psychological support. WH is an interdisciplinary, individualized, job-specific program with the express goal of return to work. WH programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. WC and WH are not intended to be sequential rehabilitation programs. WH should be considered when it appears that exercise therapy alone is not working and that biopsychosocial approaches are also needed, since single discipline programs like WC do not address these issues as WH or *interdisciplinary programs* can. (*CARF, 2006*) (*Washington, 2006*) Indications for WH are less clear for sedentary or light demand work, since on-the-job conditioning should suffice, so evaluation must demonstrate significant gaps between current level of function and realistically achievable levels required for job demands. As with all intensive rehabilitation programs, measurable *functional improvement* should occur during early WH. Progressing from WC to WH to other chronic pain programs, leading to repeating similar treatments, is unsupported by clear evidence and therefore not recommended. (*Schonstein, 2003*)

Other established guidelines: High-quality prospective studies are lacking for WH and WC, so most guidelines have been consensus based. The term "work hardening" was first introduced in the late 1970s (*Matheson, 1985*), described as a "work-oriented treatment program" with outcomes of increased productivity. A valid pre-assessment is necessary, and activities include real or simulated work activities. (*Lechner, 1994*) Early guidelines for WH 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 such programs must be "highly structured and goal oriented." Services provided by a single practitioner were excluded from CARF accreditation for WH. (*CARF, 1988*) Since 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*) Primarily offering more flexibility, types of programs covered in these guidelines are outlined below.

Single-discipline exercise approaches: Programs that utilize exercise therapy, usually appropriate for patients with minimal psychological overlay, are 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 non-

> operative therapy between acute PT and interdisciplinary/multidisciplinary programs, in accordance with the number of visits outlined in the WC/PT guidelines, which appear at the end of the ODG WH criteria.
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> *Interdisciplinary work-related exercise approaches adding psychological support:* These programs, 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). It has been suggested that WH should be aimed at individuals who have been out of work for at least 2-3 months, have failed to transition back to full-duty after more extended periods of time, and have signs 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 towards employer, fear of re-injury, fear of return to work, and interpersonal issues with co-workers or supervisors.

In this case, the IRO reviewer pointed to the absence in the request for a 20 hour work hardening program of evidence of screening documentation required by evidence-based medicine for approval of the requested treatment, including mental health evaluation, functional capacity evaluation showing current physical demand level, or the physical demand level required by Petitioner/Claimant's job which the requested treatment will attempt to allow Claimant to attain. The prescribing physician, Dr. J or other medical expert, has not provided an analysis which shows that the Petitioner/Claimant meets the threshold requirements for work hardening/work conditioning as set out in the ODG, or that there is some other evidence-based medicine that persuasively establishes that Petitioner/Claimant meets the criteria for undertaking work hardening/work conditioning. Accordingly, Petitioner/Claimant has not met his burden of proof on the issue in this proceeding.

The Administrative Law Judge considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all of the evidence whether or not the evidence is specifically discussed in this Decision and Order.

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, DWC of Workers' Compensation.

B. On (Date of Injury), Petitioner/Claimant was the employee of (Employer), Employer.

C. On (Date of Injury), Employer provided workers' compensation coverage through Indemnity Insurance Company of North America, Respondent/Insurance Carrier.

D. Petitioner/Claimant sustained a compensable injury on (Date of Injury) in the form of at least the Respondent/Insurance Carrier-accepted conditions of cervical, thoracic and left shoulder strain/sprains, and the following conditions that have been determined to be compensable by DWC: rotator cuff tear, rotator cuff tendinopathy and labral tear, all of the left shoulder; and A/C arthritis with impingement of the left shoulder.

E. The IRO determined that Petitioner/Claimant is not entitled to the disputed treatment.

2. Respondent/Insurance Carrier delivered to Petitioner/Claimant a single document stating the true corporate name of Respondent/Insurance Carrier, and the name and street address of Respondent/Insurance Carrier's registered agent, which document was admitted into evidence as Administrative Law Judge's Exhibit Number 2.

3. Twenty hours of a work conditioning program is not health care reasonable required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, DWC 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 not contrary to the decision of the IRO that twenty hours of a work conditioning program is not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Petitioner/Claimant is not entitled to twenty hours of a work conditioning program for the compensable injury of (Date of Injury).

ORDER

Respondent/Insurance Carrier is not liable for the benefits at issue in this hearing, and it is so ordered. Claimant remains entitled to medical benefits for the compensable injury in accordance with §408.021.

The true corporate name of the Respondent/Insurance carrier is **INDEMNITY INSURANCE COMPANY OF NORTH AMERICA,** and the name and address of its registered agent for service of process is

C T CORPORATION SYSTEM
1999 BRYAN ST., STE 900
DALLAS, TX 75201-3136

Signed this 17th day of May, 2019.

Warren E. Hancock, Jr.
Administrative Law Judge