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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 10/25/07

IRO CASE #:

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This case was reviewed by a Chiropractor, Licensed in Texas and Board Certified. The reviewer has signed a certification statement stating that no known conflicts of interest exist between the reviewer and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent (URA), any of the treating doctors or other health care providers who provided care to the injured employee, or the URA or insurance carrier health care providers who reviewed the case for a decision regarding medical necessity before referral to the IRO. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

20 Sessions of Work Conditioning (UPHELD)

REVIEW OUTCOME:

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

Upheld (UPHELD - Noncertify)

REVIEW OF RECORDS:

- o 1 ½" of medical records were reviewed in their entirety.
- o October 1, 2007, Peer Review, Dr.
- o October 5, 2007, Peer Review, Dr.
- o October 11, 2007, Notice of Case Assignment, Mr.
- o Consultation Report, Dr.
- o March 13, 2007, EMG/NCV report, Dr.
- o January 19, 2007, MRI of the left knee, Dr.
- o March 20, 2007, Operative Note, Dr.
- o July 9, 2007, Evaluation Report, Dr.
- o May 21, 2007, Evaluation Report, Dr.
- o March 28, 2007, Evaluation Report, Dr.
- o Evaluation Report, Dr.
- o August 27, 2007, Functional Capacity Evaluation, Dr.
- o October 3, 2007, Interim Functional Capacity Evaluation, Dr.
- o September 25, 2007, Interim Functional Capacity Evaluation, Dr.

CLINICAL HISTORY SUMMARY:

According to the medical records, the patient is an who sustained an industrial injury. He underwent an MRI of the left knee on January 19, 2007, which demonstrated acute anterior cruciate ligament rupture with associated bone contusions within the femoral condyle and tibial plateau. Grade I sprain of the medial collateral ligament complex was also noted. Acute appearing bucket handle tear involving the body and posterior horn of the lateral meniscus was identified. The inner free edge of the medial meniscus was diminutive and truncated, suggesting prior partial medial meniscectomy or perhaps a prior chronic meniscal tear. Additionally, a large knee effusion was noted and an 8 x 8 x 4 mm loose fragment anterior to the lateral meniscus within the lateral side of Hoffa's fat pad, which appears to be either a piece of avulsed

lateral meniscus from the lateral meniscal bucket handle tear or perhaps a piece of articular cartilage and subchondral bone from the posterior aspect of the lateral femoral condyle where a potential defect is suggested.

The patient underwent electrodiagnostic testing on March 13, 2007, which demonstrated the acute denervation in the L2-L3 distribution bilaterally and paraspinals T1-S1. The findings of increased reflexes at the patellae suggest possible clonus or cord involvement. There was no NCV evidence of peripheral neuropathy, plexopathy, entrapment, or peripheral nerve injury.

The patient underwent ACL reconstruction performed on March 20, 2007. The claimant underwent a functional capacity evaluation on August 27, 2007, which demonstrated that he was capable of light medium work activities. The patient was authorized for 10 sessions of work conditioning.

The patient underwent a functional capacity evaluation on August 27, 2007. He then completed 10 sessions of work conditioning followed by an interim functional capacity evaluation on September 25, 2007. The patient made mild improvements, however, not significant. For example, the patient increased his knee flexion in lateral rotation by only 11 pounds, flexion in medial rotation by 16 pounds, knee extension by 14 pounds, lift task 10 pounds, and hi near 12 pounds. Likewise, the patient's MET level on the Naughton treadmill test improved only from 2.9 to 3.2. Again, this would not be considered significant.

ANALYSIS AND EXPLANATION OF DECISION:

The medical records fail to document a defined return to work goal as agreed upon by the employer and the employee with a specific job to return to or documented on-the-job training. As noted in the Official Disability Guidelines, this is a criterion for admission into such a program. Additionally, the medical records fail to document a valid return to work effort in modified duty capacity.

Furthermore, as noted in the references, if this type of therapy is used, treatment should not exceed 2 weeks without demonstrated efficacy (subjective and objective gains). In this case, the patient made only minimal gains objectively after the completion of two weeks of the program. I would further point out that subjectively, the patient initially complained of pain 3.5-6/10 during participation of the functional capacity evaluation. This, in comparison to reported 3-5/10 during the interim functional capacity evaluation. Again, this does not demonstrate significant subjective improvement.

Therefore, recommendation is to uphold the prior noncertification for 20 sessions of work conditioning.

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

- X ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME

Official Disability Guidelines 2007, work conditioning and work hardening may be recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. 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 therapist or a multidisciplinary team, seem to be effective in reducing the number of sick days for some workers with chronic back pain, when compared to usual care. However, there is no evidence of their efficacy for acute back pain. (Schonstein-Cochrane, 2003) Multidisciplinary biopsychosocial rehabilitation has been shown in controlled studies to improve pain and function in patients with chronic back pain. However, specialized back 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. (CARF, 2006) (Washington, 2006) Use of Functional Capacity Evaluations (FCE's) to evaluate return-to-work show mixed results. See the Fitness For Duty Chapter. See Physical therapy for the recommended number of visits for Work Conditioning. For Work Hardening see below.

Criteria for admission to a Work Hardening Program:

1. Physical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.
2. A defined return to work goal agreed to by the employer & employee:
 - a. A documented specific job to return to, OR
 - b. Documented on-the-job training
3. The worker must be able to benefit from the program. Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program.
4. 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 may not benefit.
5. Program timelines: Work Hardening Programs should be completed in 4 weeks or less.

According to ACOEM guidelines, page 11, "training in body mechanics and conditioning (sometimes referred to as "work hardening") also have been advocated to prevent musculoskeletal disorders and visual fatigue. While high-grade evidence supporting the efficacy of training in body mechanics is sparse, it is a logical step (perhaps primarily to prevent recurrences) and is supported by many experienced occupational health providers. Work hardening, in the form of conditioning at hire or reconditioning after absence from work for the specific demands of the job, is also a logical step from a physiologic standpoint because deconditioning has been implicated in both initial complaints and recurrences. However, because the evidence is inconclusive, these efforts may be more cost-effective if their focus is the prevention of recurrences rather than primary prevention."