Medical Review Institute of America, Inc.
America's External Review Network

Amended Review

AMENDED REVIEW: June 4, 2008
DATE OF REVIEW: May 28, 2008

IRO Case #:

Description of the services in dispute:
Work Hardening Program and Functional Capacity Evaluations

A description of the qualifications for each physician or other health care provider who reviewed the decision
The physician who provided this review is board certified by the American Board of Physical Medicine & Rehabilitation in General Physical Medicine & Rehabilitation and Pain Medicine. This reviewer has been in active practice since 2005.

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

Partially overturn

The Work Hardening Program is medically necessary for the initial 20 days. Days 21-30 would not be considered medically necessary.

The Function Capacity Evaluations are medically necessary except for the final FCE dated 10/02/07, which is not supported as medically necessary.

Information provided to the IRO for review
1. Initial behavioral medicine evaluation dated 07/12/07
2. Work conditioning daily progress note dated 08/23/07
3. Clinical note Dr. dated 12/10/07
4. Letter of appeal , LLC
5. EOB and claim forms
6. Clinical records

Patient clinical history [summary]

The patient is a xx year old female who is reported to have sustained an injury to her right knee as a result of work related activity on xx/xx/xx. The first available medical record is a behavioral health medicine evaluation performed on 07/12/07. At this time the patient reports she sustained a compensable work related injury to her right knee on xx/xx/xx while performing her duties as a stocker. She reports she was picking up a box full of frames when she felt a pop in her right knee. She initially sought treatment from her primary care provider on 09/17/05. She was taken off work, given medication and imaging studies were ordered. On 09/19/05 the patient underwent MRI of the right knee which indicated a small knee joint effusion, a popliteal fossa cyst formation and likely bursa formation around the origin of the medial head of the gastrocnemius, subchondral cyst formation below the intercondylar eminence likely degenerative in nature, mild degenerative thinning of the medial femoral condylar cartilage to a greater extent than the lateral but no significant signal changes, a probable small focus of osteochondritis desiccans along the anterior articular surface of the internal femoral condyle. Additionally an MRI of the left knee was performed on this same date which showed small bursal fluid collection at the head of the gastrocnemius origin medially, mild chondromalacia patella confined to the lateral patellar facet cartilage with no evidence for subchondral signal changes and mild early degenerative changes. She was provided work restrictions. Subsequently the patient reports that her work restrictions were not followed by her employer. She was intermittently seen by a company doctor and received physical therapy treatments. She was subsequently referred to Dr. and received injections for pain. She is reported to have undergone MR arthrogram of the right knee on 02/16/06 which is reported to show a tear of the posterior horn of the medial meniscus near the intercondylar fossa with a probable tear of the anterior horn of the lateral meniscus, a tiny Baker's cyst and a probable ganglion associated with proximal attachment of the medial head of the gastrocnemius and there is mild degenerative change throughout the knee. Dr. subsequently took the patient to surgery on 07/20/06 and it is reported that she underwent partial medial and lateral meniscectomies and repair of the ACL. The patient subsequently transferred her care to , D.C. and the patient was referred for some level of behavioral health care. It is noted that the patient was not given a Beck Depression Inventory or Beck Anxiety Inventory. The evaluator reports the patient does not have sufficient education and literacy to understand a complete battery of formalized psychological testing and assessments and therefore they were not performed. It is the evaluator's position that given her current affect of distress it is recommended that the patient be proposed with a comprehensive return to work program with a behavioral component. This report was authored by , MA, LPC. Records indicate that the patient participated in a work conditioning program from 07/12/07-11/02/07. The record includes a clinical note from Dr. dated 12/10/07. Dr. notes the history above and indicates that the patient underwent surgery on 07/20/06 by Dr. as described above. He reports since the surgery the patient has not regained full function of her knee. She is still stiff and has some swelling. She feels like her knee is weak and cannot bend down in a squat position with full range of motion. On physical examination she has well healed surgical scars. She has good range of motion with no crepitus appreciated. She does have some difficulty in assuming a squatting position. Her right knee does appear to be slightly larger than her left due to some residual swelling. Dr. reports that he has previously recommended the patient for a work conditioning program to increase her range of motion and function of her right knee and return her to a previous

work status. She is reported to have shown some appreciable gains after completing 30 days of care. He notes that these services were not reimbursed as unnecessary medical treatment based upon a peer review. Dr. disagrees with the recommendations of Dr.. He notes that the patient participated in a brief course of PT following surgery and was referred for a work conditioning program with. The record includes a letter from, LLC which indicates that enclosed are copies of EOBs and claims. She notes the claims were denied as unnecessary medical treatment on peer review. She further reports that they are accredited and therefore preauthorization is not required.

Additional clinical records were submitted. These consist of work conditioning daily progress notes from 08/15/07 through 09/28/07. These notes indicate that the patient participated in a work conditioning program. They do not provide any significant data. It is noted that on day one of the program the patient's pain level was reported to be 4/4. Through the course of the program the patient developed elevations in pain going as high as 6. She subsequently started to reduce her reported pain levels and on the final 30th day of the program the patient had returned back to a baseline pain level of 4/4. Additional records submitted include functional capacity evaluations performed on 06/05/07, 07/31/07, 08/29/07, 09/13/07, and 10/02/07. A review of these functional capacity evaluations indicate on the initial functional capacity evaluation of 06/05/07 the patient is reported to be below sedentary to light-medium in certain functions. The subsequent functional capacity report dated 07/31/07 indicates that the patient achieved a light physical demand category. On 08/29/07 the patient is again reported to be at a light physical demand level with improvement in her lifting capacities. Her static lifting increased from 30 to 54 pounds, dynamic floor went from 20 to 40 pounds indicating that the patient was making positive progress. On 09/19/07 the patient is subsequently found to be at a medium physical demand level which is the reported requirement for her position. It would be noted that the patient's 20th visit of work hardening was on 09/13/07. This test was performed 6 days post 20th session and indicates she was meeting her job requirement. The record further includes a final functional capacity evaluation dated 10/02/07 which indicates that the patient again is at a medium physical demand level.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

The retrospective review of work hardening program from 07/12/07 through 11/02/07 and functional capacity evaluations is partially supported by the submitted medical documentation. The case which was previously reviewed by Dr. on peer review found services not to be medically necessary. Dr. 's report is not available from which to evaluate his opinion. Additional clinical records submitted by Work Conditioning Program would support the initial 20 day program. Records indicate that the patient had a favorable response to the program and by the 20th visit appears to have achieved a medium physical demand level. The patient's fourth FCE dated 09/19/07 indicates the patient is at a medium physical demand level. The patient's required PDL is medium. Treatment through 09/13/07 would be in accordance with the ODG recommendations and it is presumed that the patient had achieved a medium PDL by this date. The ODG would not have supported treatments 21 to 30. The patient has already met her required PDL and further work hardening would not have been indicated.

In regards to Functional Capacity Evaluations the final FCE dated 10/02/07 would not be considered medically necessary. The patient is documented as having reached her required physical demand level on 09/19/07. This represents a redundant study that was not medically indicated.

A description and the source of the screening criteria or other clinical basis used to make the decision:

1. The Official Disability Guidelines, 11th edition, The Work Loss Data Institute.
2. The American College of Occupational and Environmental Medicine Guidelines; Chapter 12.
3. Theodore Doege, MD, Thomas Houston, MD, et. al. The American Medical Association Guidelines to the Evaluation of Permanent Impairment, 4th edition, 4th printing; October 1999.

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