

# **INDEPENDENT REVIEWERS OF TEXAS, INC.**

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## Notice of Independent Review Decision

**DATE OF REVIEW:** 08/03/10

**IRO CASE NO.:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Item in dispute: Reconsideration of Forte's prior non-authorization of outpatient work hardening (WH) ten (10) session (80 hours) as related to the right ankle. Original decision upheld. Recommend NON-AUTHORIZATION.

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

Texas Board Certified Physical Medicine & Rehabilitation

Texas Board Certified Pain Management

**REVIEW OUTCOME**

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

Denial Overturned

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Job Description
2. 08/11/08 - Emergency Room Report
3. 08/11/08 - Radiographs Right Ankle
4. 08/18/08 - MRI Right Ankle
5. 08/20/08 - Clinical Note - Unspecified Provider
6. 08/25/08 - Letter - MD
7. 08/25/08 - Texas Work Status Report
8. 08/27/08 - Physical Therapy Notes
9. 09/05/08 - Physical Therapy Notes
10. 09/09/08 - Physical Therapy Notes
11. 09/10/08 - Clinical Note - MD
12. 09/22/08 - Physical Therapy Notes
13. 09/26/08 - Physical Therapy Notes
14. 10/03/08 - Physical Therapy Notes
15. 10/07/08 - Physical Therapy Notes
16. 10/08/08 - Physical Therapy Notes
17. 10/08/08 - Clinical Note - MD

18. 10/29/08 - Clinical Note - MD  
19. 11/03/08 - Clinical Note - MD  
20. 11/03/08 - Physical Therapy Discharge Summary  
21. 11/08/08 - Physical Therapy Discharge Assessment  
22. 12/03/08 - Clinical Note - MD  
23. 01/05/09 - Clinical Note - MD  
24. 01/26/09 - Physical Therapy Notes  
25. 02/09/09 - Clinical Note - MD  
26. 02/09/09 - Radiographs Right Ankle  
27. 03/27/09 - Clinical Note - MD  
28. 04/09/09 - Report of Medical Evaluation  
29. 04/16/09 - Designated Doctor Evaluation  
30. 04/23/09 - Functional Capacity Evaluation  
31. 05/05/09 - Clinical Note - MD  
32. 05/05/09 - Radiographs Right Foot  
33. 05/29/09 - Clinical Note - MD  
34. 06/29/09 - Clinical Note - MD  
35. 07/14/09 - Clinical Note - MD  
36. 07/21/09 - Physical Therapy Notes  
37. 09/16/09 - Letter - Heath RN, FNP-BC  
38. 09/17/09 - Functional Capacity Evaluation  
39. 09/17/09 - Report of Medical Evaluation  
40. 09/22/09 - Clinical Note - MD  
41. 10/06/09 - Clinical Note - MD  
42. 10/20/09 - Physical Therapy Notes  
43. 10/20/09 to 11/12/09 - Billing - Rehab  
44. 11/02/09 - Physical Therapy Notes  
45. 11/05/09 - Physical Therapy Notes  
46. 11/06/09 - Clinical Note - Unspecified Provider  
47. 11/10/09 - Physical Therapy Notes  
48. 11/12/09 - Physical Therapy Notes  
49. 11/18/09 - Clinical Note - Unspecified Provider  
50. 12/04/09 - Clinical Note - Unspecified Provider  
51. 12/14/09 - Independent Medical Examination  
52. 12/21/09 - Clinical Note - Unspecified Provider  
53. 01/04/10 - Clinical Note - Unspecified Provider  
54. 03/11/10 - Report of Medical Evaluation  
55. 03/19/10 - Functional Capacity Evaluation  
56. 04/05/10 - Clinical Note - DC  
57. 04/09/10 - Manual Muscle Test  
58. 04/21/10 - Clinical Note - MD  
59. 05/06/10 - Clinical Note - Unspecified Provider  
60. 05/26/10 - Letter - DC  
61. 05/26/10 - Videonystagmography/Oculomotor Studies  
62. 05/27/10 - Clinical Note - PhD  
63. 05/28/10 - Functional Capacity Evaluation

- 64. 06/03/10 - Designated Doctor Evaluation
- 65. 06/10/10 - Clinical Note - Unspecified Provider
- 66. 06/22/10 - Clinical Note - Unspecified Provider
- 67. 07/12/10 - Letter - DC
- 68. **Official Disability Guidelines**

**PATIENT CLINICAL HISTORY (SUMMARY):**

The employee is a female who sustained an injury on xx/xx/xx when she slipped and fell on the stairs.

The clinical notes begin with an evaluation in the emergency room on the date of injury. The employee reported with pain and swelling of the right ankle. Physical examination revealed limited range of motion of the right ankle due to pain and swelling. Dark purple bruising is present on the right ankle and dorsum of the right foot. The employee was prescribed Motrin 800mg. Radiographs of the right ankle performed 08/11/08 demonstrated normal findings with no evidence of fracture, bone destruction, or degenerative changes. An MRI of the right ankle performed 08/18/08 was unremarkable. A letter by Dr. dated 08/25/08 states the employee was assessed with a lateral ligamentous sprain of the right ankle. She had been recommended for physical therapy and had been provided a walking boot in order to wean off the crutches. The employee saw Dr. on 11/03/08 with complaints of continued lateral ligamentous pain. The employee was fitted with an athletic ankle brace. She was recommended to continue nonoperative treatment.

Radiographs of the right ankle performed 02/09/09 demonstrated normal findings with no evidence of fracture or dislocation.

The employee saw Dr. on 03/27/09. The employee has been unable to return to regular work. She was currently following a home exercise program. The employee was referred for orthopedic evaluation.

A Designated Doctor Evaluation was performed on 04/09/09. The employee complained of right ankle pain. The employee was unable to bear weight on the right heel. Neurological examination revealed the cranial nerves were grossly intact. Strength was normal. Deep tendon reflexes were normal. The employee was assessed with right ankle sprain/strain, right ankle pain, and plantar fasciitis of the right foot. The employee was not placed at Maximum Medical Improvement (MMI). The employee was recommended for a Functional Capacity Evaluation.

A Functional Capacity Evaluation (FCE) was performed on 04/23/09. The employee currently performed at a sedentary physical demand level with complaints of severe ankle pain throughout the evaluation. The employee's occupation as a required a very heavy physical demand level.

The employee saw Dr. on 05/05/09 with complaints of persistent pain to the right foot and ankle. Current medications included Vicodin. Physical examination of the right ankle revealed diffuse tenderness throughout the forefoot, midfoot, and hindfoot areas. There was tenderness to the plantar aspect of the metatarsal heads. Sensation was intact to light touch throughout. There was restricted ankle dorsiflexion. There was tenderness around the insertion of the Achilles tendon and along the peroneal tendons. There was pain with passive ankle range of motion. The employee reported pain in the Achilles area with full plantar contact with the floor. Radiographs revealed right foot pes planus. The employee was assessed with right Achilles tendonitis, right peroneal tendonitis, and right forefoot metatarsalgia. The employee was recommended for aggressive physical therapy.

A Designated Doctor Evaluation is performed on 09/17/09. The employee complained of intermittent right ankle pain. The employee also reported intermittent muscle spasms and cramping. Physical examination revealed the employee was able to bilateral toe walk, but was unable to bilateral heel walk due to pain. The employee was able to perform bilateral toe raise. There was negative Anterior Drawer and pivot shift in the right ankle. Range of motion of the right ankle reveals plantar flexion of 15 degrees and dorsiflexion of 5 degrees. The employee was not placed at MMI at this time.

An FCE was performed on 09/17/09. The employee demonstrated consistent, valid effort. The employee currently performed at a medium physical demand level, while her occupation required a very heavy physical demand level.

The employee was seen for evaluation on 12/04/09 with continued ankle pain complaints. Physical examination revealed minimal tenderness to the lateral malleolus. There was tenderness to the lateral malleolus and Achilles. The employee was assessed with right peroneal tendonitis, right Achilles tendonitis, and chronic matatarsalgia. The employee was recommended to follow up in three weeks.

An Independent Medical Evaluation (IME) was performed on 12/14/09. Current medications included Tylenol, Tempro, and Vicodin. The employee reported daily right ankle pain. The employee reported numbness after walking. The employee used a cane for ambulation, but had no actual limp. Physical examination revealed normal muscle strength. There was tenderness posterior to the right lateral malleolus and over the Achilles tendon and its attachment to the heel. No soft tissue or bony prominent masses were noted. The employee was placed at MMI and assigned a 0% whole person impairment.

The employee was seen on 01/04/10 with complaints of right ankle pain. The note stated the employee had been placed at MMI, and she wants to appeal this decision. Current medications included over the counter Tylenol, Vicodin, and Tramadol. Physical examination revealed the employee ambulated with an

antalgic gait. There was no edema to the ankle. There was tenderness to the lateral aspect of the Achilles. There was no crepitus noted. The employee was assessed with metatarsalgia and right ankle sprain. The note stated no follow up was anticipated.

A Designated Doctor Evaluation was performed on 03/11/10. The employee complained of an inability to bear weight on the right foot secondary to right ankle pain. The pain worsened with standing, walking, and climbing stairs. Current medications included Flexeril 10mg, Tempra 650mg, and Vicodin ES. Physical examination revealed the employee ambulated with a noticeable right limp with the assistance of a cane. The employee was unable to perform bilateral heel walk secondary to pain. The employee was able to perform full squat, and she can abdominally flex to touch her toes without difficulty. Physical examination revealed tenderness to palpation in the right lateral malleolus and posterior, inferior, and anterior to the malleolus. There was edema of the inferior and anterior aspects of the right lateral malleolus. Range of motion of the right ankle revealed plantar flexion of 35 degrees and dorsiflexion of 3 degrees. The employee was placed at MMI due to plateauing. The employee was assigned a 3% whole person impairment.

An FCE was performed 03/19/10. The employee demonstrated a consistent, valid effort. The employee performed at a light physical demand level while the employee's occupation requires a very heavy physical demand level.

The employee saw Dr. on 04/05/10 with complaints of pain, stiffness, and swelling of the right ankle. The employee rated her pain at 5 out of 10 on the VAS scale. The employee was currently ambulating with a cane and was wearing an ankle brace on the right ankle. Physical examination revealed swelling over the lateral malleolus. The employee exhibited increased weight bearing on the left leg. Weakness was noticed with left ankle dorsiflexion due to pain. Ligament laxity was not identified. No sensory deficits were noted. There was tenderness palpation to the posterolateral aspect of the right malleolus as well as the plantar portion of the right foot. There was swelling noted at the talofibular area of the right ankle. There was decreased active range of motion with pain at all end ranges. The employee was assessed with ankle joint pain. The employee was recommended for MRI of the right ankle and physical therapy. The employee was referred for orthopedic evaluation.

Manual Muscle Testing performed on 04/09/10 demonstrated significant deficit in strength with complaints of severe ankle pain. There was also a significant range of motion deficit.

The employee was recommended for an active rehabilitation program.

The employee saw Dr. on 04/21/10 with complaints of right ankle pain. Current medications included Flexeril, tramadol, Vicodin 7.5/750mg, and over-the-counter

Tylenol. Physical examination revealed limited range of motion of the right ankle. There was tenderness to palpation and swelling to the right ankle. The employee was assessed with right ankle sprain/strain, right ankle swelling, and myofascial pain/spasms. The employee was recommended to continue with physical therapy. The employee was recommended for MRI of the right ankle. The employee was prescribed Norco 5/325mg, Flexeril 10mg, and Naproxen 500mg.

A letter of medical necessity dated 05/26/10 by Dr. recommended the employee for a work hardening program. The employee had a dependence on her providers to alleviate her symptoms. The employee relied on family members to perform activities of daily living. There was evidence of psychological sequelae. The employee's condition had not resolved by pharmacological and physiotherapeutic efforts. The employee was not expected to receive further surgery. The letter stated the employee understood this program may not facilitate employment capabilities, but would focus on reduction of post-treatment care including reduction of medication dependency, interventional treatment measures, or other treatment measures including any surgical necessity.

The employee underwent videonystagmography/oculomotor studies on 05/26/10. The findings demonstrated no evidence of significant peripheral vestibular or central vestibular dysfunction.

The employee was seen for mental health evaluation on 05/27/10. The note stated the employee had been treated with fifteen physical therapy sessions and prescription medication. The employee reported difficulty with activities such as walking more than thirty minutes, standing for more than ten minutes, lifting more than five pounds, squatting, and doing chores. The employee reported sleep disturbance. The employee reported weight loss due to decreased appetite since the accident. Current medications included Flexeril 10mg, Norco 5/325mg, and naproxen 500mg. Her BDI score is 22, indicating moderate depression. Her BAI score is 18, indicating moderate anxiety. The Oswestry Disability Index totals 46 out of 100, placing her in the severely disabled range. The employee was recommended for a trial of ten sessions of interdisciplinary work hardening program. The employee was referred for psychotropic medicine evaluation.

An FCE was performed on 05/28/10. The employee demonstrated a consistent, valid effort during testing. The employee was able to perform at a frequent light and an occasional medium physical demand level while her job requires a very heavy physical demand level. The employee was recommended for a work hardening program.

A Designated Doctor Evaluation was performed on 06/03/10. The prior notes were reviewed. A physical examination was not performed. The employee was assessed with sprain/strain of the right ankle, right ankle pain, right Achilles tendonitis, and right peroneal tendonitis. The employee was placed at MMI effective 03/11/10 and was assigned a 3% whole person impairment.

The request for a work hardening program was denied by utilization review on 06/16/10 due to no indication as to the physical demand level of the proposed job.

The employee saw Dr. on 06/22/10 with complaints of pain to the lateral aspect of the right ankle. The employee rated her pain at 9 out of 10 on the VAS scale. The employee reported sleep disturbance. Prior treatments included heat, cold, prescription medications, physical therapy, and home exercises. This clinical note was incomplete.

The request for a work hardening program was denied by utilization review on 07/02/10 due to the lack of a return to work plan.

A letter of medical necessity by Dr. dated 07/12/10 noted the employee worked for the and intended to return to this position. The employee was currently unable to perform at a level that minimizes reinjury and maximized her own and a fellow worker safety. Dr. opined that a work hardening program was reasonable and provided the best opportunity for a more favorable outcome.

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

The clinical documentation provided for review does support the request for a work hardening program for ten sessions eight hours total. The employee's medical records indicate that the employee is currently not a surgical candidate and has undergone a reasonable amount of prior conservative care such as physical therapy and injections. There are no indications of any psychological issues that would suggest a poor outcome with the requested therapy. The FCE evaluations submitted for review consistently show a physical demand level less than what is required by the employee's job description. The prior denials were based on inadequate documentation regarding the indication of the employee's required physical demand level and a return to work plan. The clinical documentation does indicate that the employee requires a very heavy physical demand level based on the submitted job description. The clinical documentation also states that the employee plans to return to work in the same capacity she had prior to the injury.

As the clinical documentation adequately addresses the concerns highlighted by the prior reviews, work hardening for ten sessions eighty hours would be medically necessary.

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

1. **Official Disability Guidelines**, Online Version, Ankle and Foot Chapter