

P&S Network, Inc.

8484 Wilshire Blvd, Suite 620, Beverly Hills, CA 90211

Ph: (323)556-0555 Fx: (323)556-0556

Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 07/06/2010

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 Pain Management (Board Certified) doctor, 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

Work Conditioning (2 x 5) 10 sessions

REVIEW OUTCOME

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

Upheld (Agree)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

- o Submitted medical records were reviewed in their entirety.
- o Treatment guidelines were provided to the IRO.

PATIENT CLINICAL HISTORY (SUMMARY):

According to the medical records and prior reviews the patient is a female who sustained an industrial injury to the left knee on xx/xx/xxxx when picking up the lid of a container; the lid struck her on the left knee and she felt an immediate pop causing a hyperextension injury.

When examined onxxxxthe provider noted this is the knee that had the anterior cruciate ligament reconstruction several years prior. She is sure she re-injured the ACL graft. She had ACL reconstruction approximately about 3 years prior and was doing very well. An MRI was performed on xxxxx and given impression: ACL graft repair without evidence of re-tear. Mild grade I MCL sprain pattern. At a July 8, 2009 examination, it was determined her graft was non-functioning, although imaging did not show a re-tear. Laxity was confirmed on xxxx with KT 1000 testing. On August 5, 2009 revision ACL reconstruction was recommended.

The patient underwent surgery on October 22, 2009 of left knee ACL reconstruction with allograft.

According to a notice of dispute from the carrier the only accepted injury is a contusion to the left knee. All other conditions reported such as internal derangement and possible repeat ACL ligament tear are disputed and are considered as either pre-existing conditions, ordinary diseases of life, not related to or naturally resulting from the injury of May 8, 2009.

The patient initiated post-operative PT on November 18, 2009. X-rays taken December 7, 2009 showed the hardware in place. Following 9 of 12 authorized PT visits the patient had no swelling, incisions were well healed, she could ambulate on level surfaces with no difficulty and she was not using an assistive device. An additional 12 sessions of PT were recommended.

On January 1, 2010 the patient was reassessed in PT. She attended 12 visits of PT from 11/18/09 through 12/18/09. Additional PT has been ordered. She reports constant aching and throbbing at the left knee and tightness in the lateral aspect of the knee. She reports popping and stiffness. She is unable to fully squat. She has difficulty with ambulation and stairs. Flexion is to 75 degrees. No instability is noted. She will attend another series of 12 visits. A citation notes ODG allows 34 visits of PT following ACL repair.

Patient Job Description indicates she may need to lift up to 70 pounds maximum. She maintains grounds, plants, lawns, the parking lot, and paints as needed.

On January 4, 2010 the patient reported continued popping sensations in the knee and a feeling of instability. She reported swelling and tenderness. An FCE was recommended.

Provider note of January 20, 2010 notes the patient recently underwent an FCE, which indicated she is not quite ready to return to work. She is entitled to more therapy but will lose her job if she does not return. She will attempt light duty so as to keep her job.

On February 9, 2010 the PT notes indicates the patient is attending a second series of 12 sessions of post-operative PT following ACL reconstruction. Therapy includes instruction in HEP. She is noted to be making slow progress.

PT progress notes of February 19, 2010 indicate the patient is participating in the ACL reconstruction protocol. She requires minimal correction of her home exercise program.

PT re-evaluation of February 24, 2010 notes the patient was initially assessed in PT on November 18, 2009. She has attended 12 visits (or 24). She has been ordered another series of PT. She notes some feelings of instability in the knee but reports no buckling or giving way. She has difficulty with stairs. Flexion is to 135 degrees. She has good quad strength. There is no instability per testing. She had an injection at the last MD visit, which did not help much.

PT notes of February 26, 2010 indicate the patient fatigues before completing a full set of quad step-up exercises. She is making slow progress toward achieving goals.

The patient was evaluated orthopedically on March 22, 2010 after completing "24 sessions" of PT. She continued to complain of weakness in the leg and difficulty with activities. She is given a diagnosis of internal derangement of the knee and ACL deficient, status post revision surgery. Recommendation was for a FCE. Work conditioning/hardening would be considered. It is noted that the patient had actually attended 28-32 PT visits.

Functional Capacity evaluation was performed on April 7, 2010. The patient is 5' 8" and 214 pounds (BMI 32.5). Her job description is outlined. She is willing to return to work. She can stand for 100 minutes. She can walk on the treadmill at 1.3 mph for 20 minutes with pain behaviors demonstrated. She could ascend 3 of 5 flights of stairs when she stopped due to knee pain. She demonstrated good effort per heart rate monitoring. She was seen previously on January 6, 2010 after completing 12 sessions of PT. At that time she was recommended to attend another 12 sessions of PT. She has subsequently attended another 11 sessions of PT (35 sessions total). She reports benefit with the PT but also relates continuing functional limitations. She currently remains in a sedentary physical capacity level with continuing deficits. Her job requires a heavy-duty capacity. She also demonstrates pain behaviors. She would benefit from work hardening for education of appropriate body mechanics for return to her prior level of function and at a minimum return to gainful employment.

The FCE findings were reviewed with the patient on April 14, 2010. She is not functioning at her job level and would be at risk for re-injury at work. Recommendation is for several weeks of work conditioning and more intense therapy to the knee in order to return her to her previous level.

According to a Weekly Summary the patient had completed 5 of 10 day-sessions (20 hours completed) of work conditioning. She has shown perfect attendance at the 4-hour sessions and good effort. She demonstrates more leg strength. She is working modified duties. Fatigue after working half day is a barrier to her progress. She would benefit from taking off work for 2-3 weeks to attend a full 8-hour day program. This will be discussed with her medical provider.

On May 3, 2010 the provider noted that the patient is working and attending work conditioning. She will be taken off work for a week to allow her to concentrate on the work conditioning. She has good strength. Lachman and drawer are both 1+.

Work Conditioning Interim Summary dated May 7, 2010 notes the patient has completed 10 sessions of work conditioning with improvements in strength, work tolerance, agility, squatting, stair climbing and balance. Additional work conditioning is recommended for outdoor work tolerance. She can lift 50 pounds occasionally and 40 pounds repetitively. She was initially fatigued but after being taken off work she stayed for full day sessions without fatigue. She is currently demonstrating a medium-heavy physical demand level. Her job requires work on uneven ground.

Per the provider report of May 10, 2010 the patient has completed two weeks of work conditioning and has done very well. According to the nurse case manager, we should be able to get two more weeks in order to get her to a point where she can safely return to work.

Request for 10 sessions of work conditioning was considered in review on May 17, 2010 with recommendation for non-certification. A peer discussion was attempted but not realized. MRI revealed ACL graft repair without evidence of re-tear, mild grade I MCL sprain pattern. Evaluation of May 10, 2010 indicated the patient has had 2 weeks of work conditioning with benefit. The physical examination was unchanged (Previous evaluation gave findings of good ROM, good strength, 1+ Lachman's and 1+ drawer). The provider planned to take the claimant off work for a week to concentrate on work conditioning. The claimant has had at least 24 sessions of PT. Contact was made with an assistant who indicated the claimant was working and doing very well. ODG supports 10 visits for the claimant's diagnosis. Records do not reflect the clinical necessity for ongoing formal work conditioning on top of the 24 PT sessions and work conditioning provided to date.

Six members of the work hardening/work conditioning group met on May 21, 2010 for education in how the gate theory of pain works.

On May 24, 2010 the provider noted the patient has had a previous revision ACL reconstruction. She can return to work at light duty; however, she can only do limited work for a certain period of time. She had an extensive knee reconstruction. She would benefit from additional work conditioning.

Request for reconsideration was made on June 2, 2010 by the director of work conditioning. While the patient was noted to be

doing well she was taken off work after the first week of the program, as she was too fatigued to benefit from the program. She is a groundskeeper and she needs to perform heavy physical demand level work in extreme temperatures, on uneven terrain using heavy equipment. Given her progress in the initial 10 sessions and the demand of her job, additional work conditioning exceeding ODG recommendations is appropriate and should be authorized.

The patient was most recently reevaluated on June 7, 2010. She still has some pain and weakness status post open revision ACL reconstruction. She is being sent for a Designated Doctor Examination. Request for more work conditioning was denied.

Request for reconsideration 10 sessions of work conditioning was considered in review on June 7, 2010 with recommendation for non-certification. A discussion took place with the occupational therapist. The patient is a 40-year-old female with an unspecified injury to the left knee. MRI showed pre-existing ACL graft repair without evidence of re-tear and mild grade I MCL sprain pattern. Report of May 10, 2010 indicates she has had 2 weeks of work conditioning with benefit. The physical exam remains unchanged. The clinician planned to take the claimant off work for two weeks to concentrate on work conditioning. She has had at least 24 sessions of PT. No added clinical information was made known in the conversation. ODG limits work conditioning to the knee at 10 visits, which have been provided.

Request was made for an IRO.

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

Per ODG: Work Conditioning 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. Work Conditioning 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. Timelines: 10 visits over 4 weeks, equivalent to up to 30 hours.

Per the first-line reviewer, contact was made with an assistant who indicated the claimant was working and doing very well. ODG supports 10 visits for the claimant's diagnosis. Records do not reflect the clinical necessity for ongoing formal work conditioning on top of the 24 PT sessions and work conditioning provided to date.

In request for reconsideration the provider stated, she had an extensive knee reconstruction. She would benefit from additional work conditioning.

Per the second-line reviewer, the patient has had 2 weeks of work conditioning with benefit. The physical exam remains unchanged. The clinician planned to take the claimant off work for two weeks to concentrate on work conditioning. She has had at least 24 sessions of PT. No added clinical information was made known in the conversation. ODG limits work conditioning to the knee at 10 visits, which have been provided.

The patient has an accepted diagnosis of contusion to the knee. She has a history of a knee surgery with ACL reconstruction several years prior to her current work injury. She re-injured the knee when a trash bin lid fell onto her knee. She had a revision surgery on October 22, 2009, eight months prior and has attended at least 35 sessions of post-op physical therapy and 10 sessions of work conditioning. The second week of work conditioning the patient took off work so she would be less fatigued. She is able to work and reportedly has been doing well at work. The provider is asking for double the amount of work conditioning thus far attended. At FCE 11 weeks prior, she could stand for 100 minutes, she could walk on the treadmill at 1.3 mph for 20 minutes with pain behaviors demonstrated, she could ascend 3 of 5 flights of stairs when she stopped due knee pain. 6 weeks ago, examination showed good ROM, good strength, 1+ Lachman's and 1+ drawer. The patient is proficient in a HEP and has attended the amount of PT and work conditioning supported by ODG. The current request is for work conditioning amounting to twice the amount recommended by guidelines. The clinical findings do not establish a medical necessity for extending work conditioning past the amount supported by guidelines versus completion of rehabilitation with work and a HEP.

Therefore, my recommendation is to agree with the previous non-certification of the request for work conditioning (2 x 5) 10 sessions.

The IRO's decision is consistent with the following guidelines:

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

____ 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
- 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

The Official Disability Guidelines 06-17-2010, Knee and Leg Chapter: Work Conditioning:

Recommended as an option, depending on the availability of quality programs, and should be specific for the job individual is going to return to. There is limited literature support for multidisciplinary treatment and work hardening for the neck, hip, knee, shoulder and forearm. Work Conditioning should restore the client's physical capacity and function.

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.

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 FCE 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 be in charge of 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) Voc 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).

(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.

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