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Notice of Independent Review Decision

MEDICAL RECORD REVIEW:

DATE OF REVIEW: 09/01/2010

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

Additional work hardening of 10 sessions (80 hours)

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.
- o 10-16-06 Job Description
- o 10-28-09 CT scan, ankle read by Dr.
- o 02-09-10 Physician visit notes covering 7 visits through 05-03-10 from Dr.
- o 04-20-10 Psychological Evaluation from Dr.
- o 04-20-10 Battery for Health Improvement report from Dr.
- o 04-27-10 Work Hardening Weekly Notes/Treatment Plans, 7 reports through June 2, 2010 from Dr. and others.
- o 05-21-10 Statement of Medical Necessity from Dr.. DC
- o 05-21-10 FCE from Dr.. DC
- o 06-10-10 Pre-Certification Request from Dr..
- o 06-16-10 Adverse Determination Review from
- o 07-14-10 Reconsideration Adverse Determination Review from
- o 08-05-10 Request for IRO from the Claimant
- o 08-12-10 Confirmation of Receipt of Request for IRO from TDI
- o 08-12-10 Notice to P&S of Case Assignment from TDI

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 ankle on xx/xx/xx in a twisting injury. Her history includes a prior work injury with treatment for a left ankle sprain.

Left ankle CT scan performed showed evidence of acute or chronic avulsion injury anterior/inferior fibula at the anterior talofibular attachment.

Physician visit notes covering 7 visits from February 9, 2009 through May 3, 2010 indicate no change in the patient's symptoms. Each visit she reports constant severe inflexibility and restricted movement and stiffness in the ankle as well as sharp, shooting and throbbing pain generalized in the left medial ankle, left medial instep and left lateral ankle. The treatment provided was kinetic activities and manual therapy.

The patient was assessed psychologically for a work hardening program on April 20, 2010. She twisted her ankle. She was off work several weeks and then returned several weeks and then was taken off again. She is wearing a boot. She wants to return to work. Imaging showed an avulsion fracture fragment off the distal anterior fibula. She had a month of PT with E-stim. She does stretching. She had one injection on December 8, 2009, which was not helpful. She is using Tylenol. Her average pain is 6-7/10. She has good family support. She sleeps 8 hours per night, but sometimes the pain will wake her up. She has mild depression (BDI score is 6) and mild anxiety (BAI score is 9). She is overweight (5' 6" 180 pounds). She is recommended 10 sessions of work hardening. Battery for Health Improvement showed very low scores for any psychological weakness and high scores for functional complaints. She checked several items indicating suicidal ideation, which needed further clarification. She indicated she was very dissatisfied with her job. This testing is computer generated and the reliability is unknown.

The patient attended an FCE on May 21, 2010.

Work Hardening Weekly Progress notes and Treatment plans covering April 27, 2010 to June 2, 2010 have been submitted: On May 10, 2010 she is noted to be making progress and demonstrating no depression. She has a job to return to. She has attended 3 out of 5 days this week (60%). She is using Naprosyn 500 mg BID. On May 17, 2010 the patient is not using any medication. On May 24, 2010 the patient is not using any medication. Per the June 2, summary: She has attended 160 of 176 hours. The second week she missed 16 hours. Her BDI was zero week two, went up to 4 week four and then back down to 3.5 on week five. Her anxiety score was 9 the first week, went up to 16 the second week and was 6 as week five. Her GAF remained at 57 each week. Initially her sleep disturbance score was 3, went to 8 at the first week and stayed there until declining to 6-8 at week five. Her work level began at Medium and remained at Medium for each week. Her carry capacity was increased from 40 to 50 pounds at week four and five. Floor to knuckle increased from 15 pounds to 50 pounds, knuckle to shoulder from 40 pounds to 65 pounds and shoulder to overhead from 35 pounds to 45 pounds. Sitting tolerance went from 45 minutes to 60 minutes at week 5. Standing and walking tolerance began at 10 minutes and ended up at 45 and 40 minutes. Work simulation capacities are all noted as 35 week five with a goal of 45. Pain behaviors states "minimal."

Statement of Medical Necessity for an additional 10 sessions of work hardening dated May 21, 2010 has been submitted. The patient is using hydrocodone (?). She has a lifting requirement of 50 pounds occasionally and less than 25 pounds frequently. Her grip strength is within normal. Left ankle plantarflexion is to 14 degrees (normal = 20); dorsiflexion is to 5 degrees (normal = 10). Foot inversion is to 16 degrees (normal = 20) and eversion is to 11 degrees (normal = 10). She demonstrated a Very Heavy ability (level 9) on the treadmill. Testing indicated a current work capacity noting lifting to the waist of 40 pounds (Medium PDL), lifting to the shoulder of 60 pounds (Heavy PDL) and overhead lifting of 40 pounds (Medium PDL). She has trouble with dynamic lifting due to moderate left ankle pain and dysfunction. Her cardiovascular endurance is at a heavy PDL. She is a candidate for continued work hardening. An additional 10 sessions are requested.

On June 10, 2010 the provider requested an additional 10 sessions of work hardening (80 hours). She is using Tylenol as needed. She is currently off work and is unable to return due her physical disabilities, depression and anxiety. Her pain level is slightly higher this week; her depression has been reduced. She sleeps 6-8 hours daily, reports a pain level of 3.5/10, and has an anxiety score of 6 and a depression score of 2. She has good cardiovascular endurance (Heavy PDL), but reportedly has difficulty with dynamic lifting due moderate left ankle pain and dysfunction. Her job description require lifting and moving of 70 pounds.

Request for 10 work hardening sessions was considered in review on June 16, 2010 with recommendation for non-certification. She was initially diagnosed with left ankle/foot pain, left ankle sprain and left ankle fracture. She was given crutches, placed in a walking boot and released to modified duties. The employer was unable to accommodate. On January 5, 2010 she was referred to PT. She was diagnosed with a second degree tear of the lateral ligament of the left ankle. On January 12, 2010 she was placed on modified duty, which the employer was unable to accommodate.

She changed providers and was examined by the current provider on January 22, 2010. She was diagnosed with an unspecified left ankle sprain and effusion of the joint. She was continued on modified duty and referred to PT. She had never attended the therapy previously approved at the clinic. On February 9, 2010 she described constant severe inflexibility and restricted movement with stiffness and sharp, shooting and throbbing pain generalized in the left medial ankle, left medial instep and left lateral ankle (this complaint is reported every visit for 7 visits through May 3, 2010). On February 19, 2010 the provider noted she is in an acute care program. As of March 8, 2010 she had completed 3 of her 6 approved PT visits. FCE summary was submitted in place of the actual FCE. BDI was listed as 2 and BAI as 6. Cardiovascular was rated as Heavy and her PDL was Medium. Rationale for denial states, the claimant has previously received 20 sessions of work hardening and the current request exceeds the ODG.

An appeal was submitted on July 1, 2010. The claimant was opined to do a self-directed home exercise program. She has made excellent progress in the program. She continues to show weekly progress and has not reached a plateau. Her job requires heavy repetitive lifting of up to 70 pounds with prolonged standing and walking. Additional sessions beyond the standard of care are

recommended for this patient. Her standing tolerance is 40 minutes and her goal is 60 minutes. Further psychological treatment is needed for further understanding of how to reduce irrational fears towards re-injury, implement positive thinking, pacing,

distraction, and coping strategies during work activity to maintain low levels of pain and promote a long term return to work. She continues to have avoidance behaviors and fear of increased pain.

Request for reconsideration 10 work hardening sessions was considered in review on July 14, 2010 with recommendation for non-certification. The patient has normal levels of anxiety and depression. She has already completed 20 visits of work hardening. ODG allows for a maximum of 20 visits of the requested program, which the current request will exceed.

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, the entirety of work hardening 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.

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.

The patient is approximately 10 months post ankle sprain. The physiological reasons for her continuing pain are not clear. She did not take full advantage of prior PT but has done well with work hardening. She has completed 20 sessions (160 hours) of work hardening. There do not appear to be any medication issues. The patient demonstrated mild anxiety and depression prior to the program and her depression and anxiety scores have been lowered with the 20 visits. She does not smoke. She has good family support.

According to the Work hardening Weekly Progress notes the patient was using Naprosyn 1000 mg daily at the beginning of work hardening; by the third week she was not using any medication. The patient has a job to return to, so vocational concerns are not a factor. She has good strength and very good cardiovascular endurance but is hampered with heavy lifting due some persisting ankle pain. She did miss 16 hours (two days) of work hardening during week two (reason not stated) and it is noted that she only attended three of six therapy sessions previously approved at the industrial clinic. At her most current assessment, she has "minimal" pain behaviors.

The patient has already completed the recommended amount of work hardening per ODG and should be able to make additional gains through a HEP.

Therefore, my recommendation is to agree with the previous non-certification for 10 work hardening 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

____ AHCP- 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 08-05-2010 - Work conditioning, work hardening

Recommended as an option, depending on the availability of quality programs. See especially the Low Back Chapter or the Knee Chapter, for more information and references.

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 be 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. W C 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.

REFERENCES: ANTERIOR TALOFIBULAR LIGAMENT

The relatively weak anterior talofibular ligament passes from the anterior surface of the fibula malleolus to the talus. This ligament is actually a thickening in the anterior ankle capsule and blends imperceptibly into it. A torn anterior talofibular ligament is, therefore, a capsular injury. Ligament is 20 mm long, 10 mm wide, and 2 mm thick and it passes from the lateral malleolus to the neck of the talus. Distance from tip of fibula to center of fibular attachment of anterior talofibular ligament is 10 millimeters.

With the foot plantigrade, its fibers are oriented 75 deg to the floor; with plantar flexion, its fibers approach vertical orientation

Primary stabiliser to inversion in plantar flexion in the unloaded state, first ligament to be torn in inversion regardless of the position, tension increases in plantar flexion, in plantar flexion the ATFL aligns with the long axis of the fibula, in the neutral

position ATFL resists anterior drawer.

The accessory functions of the ATFL are resistance to anterior talar displacement from the mortise, clinically referred to as the anterior drawer, and resistance to internal rotation of the talus within the mortise.

The orientation of ATFL depends on position of ankle joint. In plantar flexion, it is parallel to long axis of foot, whereas in dorsiflexion, it is aligned with the tibial and fibular shafts. Strain in ATFL is minimum in dorsiflexion & neutral; it increased as ankle is moved progressively thru plantar flexion. [http://sportho.net/Anatomical/lowerlimb/ankle/ligaments_ankle.html]