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**Notice of Independent Review Decision**

**DATE OF REVIEW:** September 1, 2010

**IRO CASE #:**

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

Participation in a work hardening program.

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

M.D., Board Certified in Physical Medicine and Rehabilitation.

**REVIEW OUTCOME**

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

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

Participation in a work hardening program is not medically necessary for treatment of the patient's medical condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

1. Request for a Review by an Independent Review Organization dated 8/5/10.
2. Confirmation of Receipt of a Request for a Review by an Independent Review Organization (IRO) dated 8/10/10.
3. TDI Notice to Utilization Review Agent of Assignment of Independent Review Organization dated 8/11/10.
4. TDI Notice to IRO of Case Assignment dated 8/11/10.
5. Clinic Note from Orthopaedics and Spine Specialists dated 2/4/09.
6. Record Review from MD dated 2/10/09.
7. Rehabilitation Services Outpatient Questionnaire dated 3/6/09.
8. Rehabilitation Services Attendance Grids and Flow Charts dated 3/6/09 through 5/8/09.
9. Rehabilitation Services Outpatient Questionnaire dated 3/6/09.
10. Independent Medical Examination and History and Physical Exam from dated 4/10/09.
11. Impairment Rating Report dated 6/10/09.
12. Medical records from dated 1/20/09 and 4/16/10.
13. Pre-Certification Request from dated 5/18/10.
14. Request for an Appeal from dated 6/9/10.
15. Denial documentation dated 5/26/10 and 6/28/10.

**PATIENT CLINICAL HISTORY [SUMMARY]:** A review of the record indicates the patient is a male who sustained a work related injury on xx/xx/xx. According to the submitted information, the patient fell off of a ladder, injuring his left leg. He sustained a left knee tibial plateau fracture and left talus fracture. The patient underwent open reduction and internal fixation of the tibial plateau fracture and immobilization of the left ankle fracture. The patient continues to have left ankle pain and is noted

to limp with ambulation. His provider indicates that the patient is not at a pre-injury activity level and cannot currently meet the physical demands of his job. The provider further indicates that the patient has participated in 19 sessions of physical therapy with progress followed by a plateau. The patient is seeking coverage for participation in a work hardening program. The Carrier indicates the disputed services are not medically necessary. The Carrier states the patient has only undergone 19 physical therapy treatments to date.

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

The patient is now approximately 19 months post injury from his left tibial plateau and left talus fractures. He has had 19 sessions of physical therapy and has recently plateaued in his recovery. He has been observed limping when not performing any additional stress to the ankle such as running, carrying, squatting, etc. Examiners have also noted an audible click when the patient is ambulating. Given these findings, the patient is not an appropriate candidate for a work hardening program at this time. Participation in such a program would add further stress to the ankle in the form of additional weight bearing load and/or increased time of weight bearing. Increased stress to the left ankle is likely to be associated with worsening ankle pain. Additionally, there is a lack of evidence that the patient has a pathology that is likely to benefit from participation in a work hardening program. Furthermore, the submitted evidence does not establish that the patient meets Official Disability Guidelines for work hardening which requires that surgery and other treatments be ruled out, specifically, “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). All told, the evidence does not demonstrate that the proposed program is likely to increase the patient’s functional capacity. In conclusion, I have determined that the requested service is not medically necessary for treatment of the patient’s medical condition.

**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 KNOWLEDGBASE
- 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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)