MEDRx

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Notice of Independent Review Decision

DATE OF REVIEW: 4-18-2011

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
The item in dispute is the prospective medical necessity of 10 days of work hardening.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
The reviewer is a Medical Doctor who is board certified in Physical Medicine and Rehabilitation. This reviewer has been practicing for greater than 10 years.

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)

The reviewer disagrees with the previous adverse determination regarding the 10 days of work hardening.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

PATIENT CLINICAL HISTORY [SUMMARY]:

Injured Worker sustained a work related injury to the left knee XX/XX/XXXX. According to the records he tripped against a steel cable and twisted his left knee. On 10/19/2010 The injured worker underwent ACL reconstruction and a partial medial meniscectomy of the left knee. Records of the procedure were not made available for this review.

The injured worker had postoperative rehabilitation including physical therapy from November
16, 2010 through January 26, 2011. According to the therapy notes he responded to therapy. Pain decreased but did not resolve. In December the injured worker tolerated an increase of weights in the resistance exercises and was able to begin treadmill exercise and stationary bicycle exercise. After completion of the therapy program he continued to have knee pain
with physical activity, with some restriction of knee motion.

A functional capacity evaluation was done February 1, 2011 wherein the injured worker performed dynamic lifting activities at a Light PDL on an occasional basis. The report documented that the injured worker's job is classified as a Medium PDL. Despite good effort, deficits were documented in prolonged walking, lifting occasionally, carrying, crouching and kneeling. There was impairment of work endurance, cardiorespiratory fitness, functional range of motion of the left knee, and pain levels ranging from 3 to 5 on a 0-10 pain scale.

Request for Authorization of Work Hardening Program was submitted February 10, 2011. On
February 16, 2011 the proposed treatment program was non-authorized.

A request for reconsideration was submitted. Results of the FCE were discussed. The testing results placed the injured worker at a light to medium PDL, whereas the job description required a medium PDL. The injured worker stated that he performs work which is readily available in the business for someone with his skills and experience. On March 7, 2011 the non-authorization was upheld on reconsideration.

On March 23, 2011 the injured worker was seen for orthopedic follow-up, complaining of left knee pain at level 3 on a scale of 1-10. Examination revealed mild crepitus and mild effusion of the left knee, with anterior and medial knee pain, with no evidence of instability. The gait was antalgic. The surgeon noted that the patient was 6 months postop from his anterior cruciate ligament reconstruction and medial meniscectomy of the left knee. "The patient is evolving well but still has residual quadriceps atrophy, weakness and pain at the knee". He concluded that the patient needs additional physical therapy for his left knee: "It is not unreasonable for patients to require more than 6 months of physical therapy following
anterior ligament reconstruction and medial meniscectomy. I would therefore recommend an additional 4 weeks of strengthening. This should be followed by a functional capacity evaluation".

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

Based on the records submitted for review, the requested procedure is recommended at this time.

As cited in the ODG Guidelines, the CARF definition of Work Hardening "A highly structured, goal oriented, individualized treatment program designed to return the person to work." Work hardening programs use real or simulated work activities designed to restore physical, behavioral, and vocational function.

According to the documents submitted for review, the proposed treatment program for the injured worker meets the following criteria from the ODG Treatment Integrated Treatment/Disability Duration Guidelines pertaining to the Knee & Leg (Acute & Chronic) (updated 03/21/11):

Criteria for admission to a Work Hardening (WH) Program:

- 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).
- 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.
- 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.

- 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.
- 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.
- 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.
- 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.
- 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.

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 FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**