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## **Notice of Independent Review Decision**

**DATE OF REVIEW:** 11/28/11

**IRO CASE #:**

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

Ten sessions of work hardening (80 hours)

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

Board Certified in Orthopedic Surgery

### **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)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Ten sessions of work hardening (80 hours) - Upheld

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

An emergency room record from N.P. at Doctors Hospital dated 02/24/11

X-rays of the left forearm, cervical spine, left ribs, right ankle, and right tibia and fibula at Doctors Hospital dated 02/24/11 and interpreted by M.D.

An Employer's First Report of Injury or Illness dated xx/xx/xx

Another emergency room record from an unknown physician at Doctors Hospital dated 03/18/11

A lower extremity venous Doppler dated 03/18/11 and interpreted by Sr.

An Employee's Claim for Compensation for a Work Related Injury DWC Form 41 dated 03/28/11

Evaluations at the Institute for Wellness from F.N.P. and M.D. dated 03/28/11 and 10/18/11

An MRI of the right ankle dated 03/31/11 and interpreted by, M.D.

DWC-73 forms signed by Dr. on 04/12/11, 04/19/11, 05/17/11, 07/06/11, 09/16/11, and 10/18/11

HBO evaluations dated 04/21/11, 05/06/11, 05/13/11, 05/20/11, and 05/27/11 with M.D.

Wound care daily notes from the Medical Center dated 04/29/11, 05/13/11, and 06/17/11

A Test dated 04/30/11 with Dr. Lozano

Functional Abilities Evaluations (FAE) dated 05/10/11 and 08/04/11 with Mr.

Letters "To Whom It May Concern" from Dr. dated 06/03/11 and 08/04/11

A three phase bone scan dated 08/31/11 and interpreted by D.O.

A Work Hardening Mental Health Consultation dated 09/09/11 with M.A., L.P.C.

A Utilization Review Determination dated 10/06/11 from M.D. with Inc.

Another Utilization Review Determination dated 10/26/11 from M.D. from Direct, Inc.

The Official Disability Guidelines (ODG) were not provided by the carrier or the URA

## **PATIENT CLINICAL HISTORY**

The Employer's First Report of Injury or Illness stated the patient's right lower leg/right ankle was crushed between a trailer and a wall on xx/xx/xx. The patient presented to the emergency room on 02/24/11 for a slip and fall injury to the

back. She was diagnosed with a cervical strain. X-rays were normal, except for bimalleolar soft tissue swelling in the right ankle. She then presented to the emergency room again on 03/18/11 for a crush injury to the right lower extremity. On 03/28/11, Mr. and Dr. evaluated the patient for her right calf, heel, and ankle pain with swelling. An MRI of the right ankle on 03/31/11 revealed marrow edema in the distal shaft of the fibula and in the lateral malleolus with edema in the overlying subcutaneous fat, likely contusional edema. There was a poorly defined collection in the medial aspect of the lower leg, appearing hyperintense on the T1W images, which suggested a hematoma, with mild adjacent subcutaneous edema, likely due to trauma. On 04/21/11, Dr. examined the patient and recommended a SensiLase test to evaluate for oxygenation since the patient had diminished pulses, which was performed on 04/30/11. Wound care daily notes were provided for review dated 04/29/11, 05/13/11, and 06/17/11. On 05/06/11, Dr. recommended debridement and follow-up MRI regarding the right leg crush injury. An FAE on 05/10/11 indicated the patient was functioning in the medium physical demand level and her previous employment required the heavy physical demand level. A work hardening/conditioning program was recommended. On 05/20/11, Dr. noted the right leg ulcer was improving in size and in character, but the MRI had not yet been approved. Dr. noted on 05/27/11 that the patient underwent the MRI, which showed muscular edema with no signs of osteomyelitis or fractures. Dr. recommended increased physical therapy. On 06/03/11, Mr. and Dr. requested 12 additional sessions of physical therapy for the right ankle and on 08/04/11, recommended eight additional sessions of therapy. The patient underwent another FAE on 08/04/11 and continued to function in the medium physical demand level. A triple phase bone scan on 08/31/11 revealed findings consistent with cellulitis of the right lower leg, particularly medially. Osteomyelitis was not suspected. Mr. performed a mental health consultation on 09/09/11 and recommended 20 days, at eight hours a day, of work hardening. On 10/06/11, Dr., for, Inc., provided an adverse utilization review determination for the requested 10 sessions of work hardening (80 hours). Dr. and Mr. reexamined the patient on 10/18/11 and noted 1+ edema in the right ankle with tenderness and muscle spasm. She was asked to follow-up on 11/18/11. On 10/26/11, Dr. for, Inc. provided an adverse utilization review determination for the requested 10 sessions of a work hardening program (80 hours).

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

The evidence based ODG have the following criteria for admission to a work hardening 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, further employability, and time off work
  - B. Review of systems including other non-work related 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 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 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 median or high demand level, i.e., not clerical/sedentary work. There should generally be evidence of a valid mismatch between documents specific and essential to job task 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 maximum effort and demonstrate capacities below an employer-verified physical demand analysis. Inconsistencies or indications that the patient has performed below maximal effort should be addressed prior to treatment in these programs.

5. Previous physical therapy: There is evidence of treatment with a 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 indications 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 four hours a day for three to five days a week.

8. Other contraindications: There is no evidence of other medical, behavioral, or other co-morbid conditions (including those that are non work-related) that prohibits participation in the program or contradicts successful return-to-work upon program completion.

9. Return to work 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 patient's current validated abilities.

10. Drug problems: There should be documentation that the patient'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 evaluations: 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 one to two 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. Currently 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. Vocational Rehabilitation: 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 two 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 eight to twelve 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 four to eight hours with treatment ranging from three to five visits per week. The entirety of this treatment should not exceed 20 full day visits over four 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 one to two 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 reasons for termination including successful program completion or failure. This would include noncompliance, declining further services, or limited potential of benefit. There should also be documentation that 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.

There is a lack of documentation of previous physical therapy and return to work plan as required in the ODG criteria for admission into a work hardening program. Even if all criteria were met, which is not the case, a trial would be indicated for a maximum of one to two weeks with objectively documented reassessment at that point. Non-physical factors appear to be a significant impediment to her functional restoration. There are no objective physical deficits documented to preclude return to work at this time. Additionally, it is unclear based on the records if the patient is physically able to complete the work hardening program as recommended, as she is noted to be non-weightbearing and on crutches. She also appears to have psychosocial stressors and negative predictors of success that has not been addressed based on the documentation. Furthermore, although the staffing agency the patient works for is willing to take her back at the heavy physical demand level, there is no documentation of any job or occupation for her to return to once she completes a work hardening program. Therefore, the requested 10 sessions of a work hardening program (80 hours) would not be reasonable or necessary and the previous adverse determinations should be upheld.

**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 AND KNOWLEDGE BASE**
- 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)