



IMED, INC.

11625 Custer Road • Suite 110-343 • Frisco, Texas 75035
Office 972-381-9282 • Toll Free 1-877-333-7374 • Fax 972-250-4584
e-mail: imeddallas@msn.com

Notice of Independent Review Decision

DATE OF REVIEW: 03/23/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

80 Hours of work hardening for the left foot and lower leg

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

Board Certified Chiropractic Examiner

REVIEW OUTCOME:

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

Upheld (Agree)

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.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

Partial clinic note initial consultation Injury Center of Houston, provider unknown
Clinic note Dr. dated 11/14/11
Electrodiagnostic studies dated 12/01/11
Claimant D.C. dated 12/14/11
MRI ankle dated 12/21/11
Functional capacity evaluation dated 01/16/12
Psychiatric evaluation dated 01/30/12
Employee job description

Request for work hardening dated 02/09/12 and 02/23/12
Physical performance evaluation dated 02/22/12
Utilization review determination dated 02/16/12
Utilization review determination dated 03/02/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who is reported to have sustained work related injuries on xx/xx/xx. It was reported on date of injury he was working on a tray table 20 feet long which subsequently fell on his left leg and foot which caused moderate laceration to the left leg. He was initially seen at emergency department at Hospital in. Radiographs were taken without evidence of fracture. There was significant swelling. His wounds were dressed and he was recommended to follow-up with primary care provider and recommended for possible MRI. The claimant subsequently came under care of Injury Center of on 09/30/11. He is reported to have difficulty standing and walking and reported pain to left ankle, left foot and toes. He has been off work. His current medications include Vicodin and Hydrocodone. He was reported to have antalgic gait. He is reported to have wound dressed with gauze at anterior tibialis region. The area around laceration has ecchymosis. The remainder of the note is not available for review. On 11/14/11 the claimant was seen by Dr.. The claimant reported complaints of pain and numbness to left foot and toes. On examination he has decreased sensation over L5-S1 dermatome on left foot. He walks with limp. He was recommended to undergo imaging studies and electrodiagnostic studies. EMG/NCV performed on 12/01/11 reported to be normal and shows no evidence of radiculopathy or peripheral neuropathy or neural compromise. Records indicate the claimant continued under the care of Dr., D.C. He is noted to have undergone sessions of physical therapy with continued significant pain and was referred for MRI of left ankle. This study is essentially normal and there was no evidence of ligamentous or tendinous disruption, bone contusion, or fractures. Laceration was not identified on imaging. There is mild Achilles tendinosis with tiny retrocalcaneal spur. The claimant underwent a functional capacity evaluation on 01/16/12. It was reported he provided reliable effort. He was opined to be capable of performing work at light physical demand level.

Psychiatric evaluation was performed on 01/30/12. BDI was 24 in moderate to severe range and BAI is 5. There is suggestion the claimant participated in work hardening program.

On 02/09/12 a request for 10 sessions of work hardening was submitted by, D.C.

On 02/22/12 the claimant underwent functional capacity evaluation. He is noted to be able to perform at medium physical demand level.

On 02/23/12 Dr. submitted second request for work hardening program. He notes Dr. denied request and stated the claimant had contusion of ankle. He notes the claimant is reported to require heavy physical demand level. He provides further data to support this request.

On 03/02/12 the appeal request was reviewed by, D.C. Dr. Murphy non-certified the request for 80 hours of work hardening noting the claimant has undergone physical therapy without evidence of functional improvement. Functional capacity evaluation following physical therapy

indicated he was only functioning at a light physical demand level and he is reported to have decreased cardiovascular condition and poor endurance levels. He noted functional capacity evaluation dated 02/22/12 demonstrated the claimant has improved a full physical demand level category in one month without any intervention. He finds the request for work hardening is not supported. Telephonic consultation was performed but did not alter outcome of review.

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

The request for 80 hours of work hardening for left foot and lower leg is not supported as medically necessary. Per the submitted clinical records the claimant sustained contusion and laceration to lower extremity. He subsequently has complaints of left ankle and foot pain not validated by imaging studies. The submitted clinical records do not provide detailed information regarding treatment to date. He appears to have had at least 12 sessions of physical therapy. MRI of ankle is unremarkable. EMG/NCV is normal. Initial functional capacity evaluation on 01/16/12 indicates the claimant can perform at light physical demand level. He subsequently underwent repeat functional capacity evaluation without interventions between and achieved medium physical demand level. It would further be noted the claimant's psychiatric evaluation showed the claimant has moderate to severe levels of depression, yet his BAI was only 5. This is inconsistent with elevated depression score. Further, there is no indication the claimant has been referred for individual psychotherapy or been placed on anti-depressants prior to recommendation to participate in this program. Therefore, the individual counseling that would occur would be of little or no benefit. Based on information submitted, the request does not meet the *Official Disability Guidelines*.

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

X MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

X ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

The 2012 Official Disability Guidelines, 17th edition, The Work Loss Data Institute. Online edition.

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. 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.