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Notice of Independent Review Decision

DATE OF REVIEW: June 12, 2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

97545 Initial Work Hardening Program x 80 Hours, 97546 Initial Work Hardening Program Add-On

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

This physician is a Board Certified Physical Medicine and Rehabilitation Physician with over 18 years of experience.

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:

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx/xx/xx male who injured his right knee on xx/xx/xx when he was taking a bicycle from an upper bike rack and his knee buckled. He is status post right ACL reconstruction performed on December 6, 2011.

07/15/11: The claimant was evaluated by MD for complaints of right knee pain following a work injury. On physical exam, he demonstrated moderate tenderness to the right knee with no muscle spasm, no sensory/motor deficit, no edema, no erythema, a mild antalgic gait, normal reflexes, negative SLR, restricted ROM,

and effusion present. A knee brace was applied to the right knee. He was given prescriptions for Prednisone and Ultracet.

10/11/11: MRI Right Knee Interpreted by MD with Imaging. IMPRESSION: 1. Abnormal ACL consistent with high-grade partial tear or complete tear. Probably a complete tear. 2. Partial tearing of the lateral capsule but the lateral ligaments are intact. 3. Normal PCL and MCL. 4. Oblique tear posterior horn lateral meniscus. 5. Vertical peripheral tear posterior horn medial meniscus without displaced meniscal fragment. This appears to be a red zone tear. 6. Large joint effusion with edema in Hoffa's fat pad.

12/06/11: The claimant was admitted to xxxxx where he underwent a right anterior cruciate ligament repair using amniotic membrane allograft, partial mediolateral meniscectomy, complete synovectomy, and removal of adhesions by MD. Upon discharge, he was given a prescription for Norco.

01/05/12: The claimant was evaluated by DC who noted that he rated his pain as 6/10. He reported an increase in pain after standing/walking for approximately two hours. He also reported difficulty climbing stairs and difficulty squatting. On physical exam, knee flexion ROM was 115 degrees with increased pain. Bilateral lower extremity strength was 5/5. Sensation was within normal limits. He was tender to palpation of the anterior aspect of the knee. PLAN: Rehabilitation 3 days/week x 4 weeks.

01/12/12, 01/13/12, 01/16/12, 01/18/12, 01/20/12, 01/25/12, 01/27/12, 01/30/12, 02/03/12, 02/06/12, 02/08/12, 02/13/12, 02/29/12, 03/05/12, 03/19/12, 03/23/12, 03/26/12: The claimant was evaluated by DC. On visit 1, 01/12/12, the claimant was able to tolerate treatment plan with increased discomfort observed with theraband and isometric exercises. On visits 2-10, the claimant was compliant and able to tolerate treatment plan with no tenderness to palpation reported and he was able to tolerate exercises. On visits 11-17, 02/08/12 – 03/26/12, the claimant was complaint and able to tolerate treatment plan with ROM within normal limits and no tenderness to palpation reported. There was no guarding or altered ambulation observed.

02/13/12: The claimant was re-evaluated by DC who noted that he reported improvement with therapy. He denied pain at rest and reported an increase in pain with activity and rated it at 5/10. He reported increased activity tolerance but continued to report elevated pain after approximately two hours of standing and walking and with squatting. On physical exam, flexion ROM was 130 degrees. Bilateral lower extremity strength was 5/5. Sensation was within normal limits. No tenderness to palpation was reported. PLAN: Patient completed 12 therapy visits, was compliant with care and responded well to therapy. He continues to report increased pain with prolonged activity. Six (3x2) additional therapy visits are recommended with focus on work stimulated activities and increasing activity tolerances.

02/28/12: Functional Capacity Evaluation by, DC. ASSESSMENTS: The evaluatee cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes.

03/19/12: The claimant was evaluated by MD who noted that he was improving but still had decreased balance. On physical exam, he had diffuse tenderness in the right knee. He was released of treating.

03/26/12: The claimant was re-evaluated by DC who noted that he rated his pain at 4/10. On physical exam, flexion ROM was 135 degrees. Bilateral lower extremity strength was 5/5. Sensation was within normal limits. There was no tenderness to palpation reported. PLAN: Patient completed postop therapy and was compliant with care. A FCE is scheduled for further functional assessment and to evaluate if patient is able to perform his regular job duties and return to work.

03/30/12: Physical Performance Evaluation by DC. ASSESSMENTS: 1. The evaluatee cannot safely perform their job demands based on comparative analysis between their required job demands and their current evaluation outcomes.

03/30/12: Patient Report of Work Duties. 1. Stock and carry 10-50 pound weights daily. 2. Stock and carry tools up to 40 pounds in hardware daily. 3. Stock and carry TV stands and book shelves up to 100+ pounds daily. 4. Zoning the departments I do that night. 5. Code 17 pushing buggies back to stations so customers can use them. 6. Assisting customers with pain, 5-20 pounds. 7. Taking boxes to compactor. 8. Cleaning spills. 9. Bringing damaged goods to claims. 10. Tag teaming others departments when they fall short of time. CONTACT WITH EMPLOYER on 04/20/12: Weight requirements: 100 lbs. Return to Work Options: Heavy, very heavy. Goal: PDL Very Heavy (100 lbs).

04/12/12: The claimant was evaluated by , MS, LPC, BCN. TREATMENT RECOMMENDATION/PLAN: We concur with, MD's recommendation that the patient participate in a Work Hardening Program as Mr. has exhausted conservative treatment yet continues to struggle with pain and functional problems that pose difficulty to his performance of routine demands of living and occupational functioning. Thus, it is recommended that Mr. be approved for participation in the Work Hardening Program in order to increase his physical and functional tolerances and to facilitate a safe and successful return to work.

04/12/12: The claimant was evaluated by MD. On physical exam, there was slight right knee effusion noted. Flexion 120 degrees, extension 0 degrees. PLAN: 1. In view of patient's history and physical he will be an excellent candidate for the work hardening program. 2. Above discussed with patient at length. 3. I will recheck patient in 2 weeks.

04/20/12: Work Hardening Program Pre-Authorization Request. Because the patient is not able to meet the requirements to safely return to work without re-

injury/aggravation, the patient is likely to benefit from a Work Hardening Program at this time. The patient is currently not working. The patient is likely to meet the required PDL to safely return to work with this program. The patient will be evaluated on a regular basis, and it is our expectation that they will return to pre-injury work status upon completion of the program. We expect they will regain full-duty status upon completion of the program.

04/25/12: UR performed by MD. Rationale: The individual sustained an ACL tear 07/13/11 and underwent ACL reconstruction on 12/06/11. There were 16-18 postop therapy visits completed. No return to work attempt. Current request is for 80 hours of work hardening. Intake functional capacity evaluation (FCE) indicates patient functioning at Heavy physical demand level (PDL) (with 80/40 lbs. lift capability), but FCE indicates by 'patient report' that the needed PDL is Very Heavy. His position as was a 50-70 lbs. max lift and is generally categorized in the Medium or Medium /Heavy PDL. Dr. I references verbal communication with the employer indicating the patient would be required to lift and carry 100 lbs. for 8 hours per day as a result of their usual job. This is inconsistent with the written job description. There is no job mismatch and therefore medical necessity is not established. Recommend denial. Patient should be physically ready for return to work trial.

05/08/12: Reconsideration request. Rationale: We are not sure where Dr. got 50-70 lb max lift description for his night stocker position and how he assumes his job is in medium to medium/heavy PDL. Mr. filled out a patient report of work duties (the heaviest thing he does is stocking and carrying TV stands and book shelves up to 100 pounds on a daily basis) and we called his employer to verify. We called his employer on 04/20/12, and they also classified his job as very heavy. Looks like he attempted light duty for several months up to the point he had surgery. He has been off work ever since. Dr. has not released him to return to work yet.

05/15/12: UR performed by DO, MS. Rationale: Employer job description is not provided. Employer contact is not recorded. This employer provides modified duty and can certainly find work for someone at a heavy physical demand level (PDL). Called 05/11/12 at 08:35 am CST, I spoke and left a message for a peer to peer. 05/11/12 at 10:30 am CST, I spoke with Dr.. He was able to agree that the employee has the physical ability to do work up to 80 lb. He confirms that since the surgery, there has been no trial of return to work at current PDL. He is unable to provide me with the name of the contact person at who reported that the patient has to lift 100 lb. There are not physical barriers to return to work. Off work status is clearly not medically reasonable. Work Hardening is clearly not indicated.

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

The previous adverse decisions are upheld. Review of the records submitted indicate a male who injured his right knee on xx/xx/xx when he was taking a bicycle from an upper bike rack and his knee buckled. He underwent a right anterior cruciate ligament repair (using amniotic membrane allograft, partial mediolateral meniscectomy, complete synovectomy, and removal of adhesions) by MD, on xxxx. He initially received xxx postoperative physical therapy sessions with notes reflecting “ROM within normal limits and no tenderness to palpation reported,” and “no guarding or altered ambulation observed”. Physical therapy notes indicate 6 additional physical therapy sessions were completed as ordered by DC, to “focus on work simulated activities”. There are no notes indicating a trial of return to work at claimant’s functional level of heavy PDL (as reported per intake FCE). Per Dr. notes on 05/15/12, Dr. agreed that claimant was able to do work up to 80 lbs and that he was unsure who reported claimant would need to lift up to 100 lbs.

As per ODG’s recommendations for work conditioning/hardening, there should be “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” and “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).” Notes indicated that on 03/19/12, Dr. released the claimant from his treatment. Records do not clearly reflect a valid mismatch of job specific tasks and claimant’s ability to perform them. Additionally, records suggest claimant would be able to safely return to work at his current functional level as per Dr. Dr. noted conversation with Dr. on 05/15/12. Therefore, the request for 97545 Initial Work Hardening Program x 80 Hours, 97546 Initial Work Hardening Program Add-On is not medically necessary and is noncertified.

ODG:

<p>Work conditioning, work hardening</p>	<p>Criteria for admission to a Work Hardening (WH) Program:</p> <p>(1) <i>Prescription:</i> The program has been recommended by a physician or nurse case manager, and a prescription has been provided.</p> <p>(2) <i>Screening Documentation:</i> 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.</p>
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	<p>(3) <i>Job demands</i>: 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).</p> <p>(4) <i>Functional capacity evaluations (FCEs)</i>: 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.</p> <p>(5) <i>Previous PT</i>: 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.</p> <p>(6) <i>Rule out surgery</i>: 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).</p> <p>(7) <i>Healing</i>: 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.</p> <p>(8) <i>Other contraindications</i>: 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.</p> <p>(9) <i>RTW plan</i>: 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.</p> <p>(10) <i>Drug problems</i>: 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.</p> <p>(11) <i>Program documentation</i>: 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.</p> <p>(12) <i>Further mental health evaluation</i>: 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.</p> <p>(13) <i>Supervision</i>: 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.</p> <p>(14) <i>Trial</i>: Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by</p>
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	<p>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.</p> <p>(15) <i>Concurrently working</i>: 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.</p> <p>(16) <i>Conferences</i>: There should be evidence of routine staff conferencing regarding progress and plans for discharge. Daily treatment activity and response should be documented.</p> <p>(17) <i>Voc rehab</i>: 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.</p> <p>(18) <i>Post-injury cap</i>: 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).</p> <p>(19) <i>Program timelines</i>: 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.</p> <p>(20) <i>Discharge documentation</i>: 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.</p> <p>(21) <i>Repetition</i>: 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.</p> <p><i>ODG Work Conditioning (WC) Physical Therapy Guidelines</i></p> <p>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.</p>
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	<i>Timelines:</i> 10 visits over 4 weeks, equivalent to up to 30 hours.
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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)**